Report on Suicide and Suicide Prevention in Texas

As Required by

House Bill 3980, 86th

Legislature, Regular Session,

2019

Health and Human Services

Commission

May 2020

TEXAS
Health and Human Services

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Executive Summary

The *Report on Suicide and Suicide Prevention in Texas* is submitted in compliance with House Bill (H.B.) 3980, 86th Legislature, Regular Session, 2019. The bill requires a summary report on the prevalence of suicide in Texas as well as state policies and programs adopted across state systems and agencies to prevent suicides.

The Health and Human Services Commission (HHSC) oversees suicide prevention in Texas with collaboration from other state agencies. The primary goal is to prevent all suicide deaths and connect individuals with appropriate behavioral health services at the right time and place. As a first step toward achieving this goal, it is critical to understand prevalence rates of suicide-related events, including suicidal thoughts, suicide attempts, and deaths caused by suicide. Since the year 2000:

- Texas has seen an overall increase in suicide mortality with the death rate rising 36 percent;
- Individuals ages 55-64 saw the greatest increase of any age group with a 61 percent increase in deaths by suicide;
- The rate of suicide mortality in women has increased by 50 percent;
- The rate of high school males who have attempted suicide has more than doubled; and
- The veteran suicide death rate rose 32 percent between 2005 and 2017.

Due to the way data are collected on the Texas death certificate, suicide rates for active military members could not be calculated.

With Texas' large size and varied geography, it is important to analyze death by suicide prevalence rates with respect to location, showing since the year 2000:

- Public Health Region 2 (area west of Dallas-Fort Worth) experienced the largest increase in the suicide death rate with an increase of 62 percent;
- Public Health Region 5 (lower East Texas) experienced the lowest increase in the suicide death rate with an increase of three percent;
- The suicide mortality rate in non-metro areas is about 30-45 percent higher than the rate in metro areas; and
- The suicide mortality rate is increasing faster in non-metro areas than in metro areas.

For a comprehensive understanding of suicide prevention work in Texas, it is vital to recognize the existing state statutes, agency rules, and policies relating to suicide prevention, intervention, and postvention.

The Texas Education Code, Texas Family Code, Texas Health and Safety Code, Texas Civil Practice and Remedies Code, Texas Occupations Code, Texas Human Resources Code, Texas Penal Code, Texas Code of Criminal Procedure, Texas Government Code, and Texas Property Code all contain guidance relating to suicide prevention that affects the work of school personnel, mental health professionals, individuals working in the criminal and juvenile justice systems, and child welfare employees, among many others. These state statutes are included in this report, along with state agency initiatives since 2000 addressing suicide and suicide prevention.

As required by legislation, the Texas Suicide Prevention Council was consulted and worked with HHSC on the development of this report.

Per H.B. 3980, 86th Legislature, Regular Session, 2019, this summary report on the status of suicide prevention in Texas will inform the subsequent legislative report to be completed by the Statewide Behavioral Health Coordinating Council (SBHCC) on suicide in this state. The legislative report will identify opportunities and make recommendations for state agencies regarding improving data collection for suicide-related events, using data to inform decisions and policy development relating to suicide prevention, and decreasing suicide in Texas.

1. Introduction

As H.B. 3980 states, suicide is a public health crisis affecting residents of all ages in every region of the state. Developing a shared understanding of suicide in Texas will help determine the appropriate state and regional efforts necessary to decrease state suicide rates and address the disparities in state laws, policies, programs, and efforts currently being used to address suicide.

H.B. 3980 requires HHSC to write a report gathering available data on suicide, suicide attempts, and suicidal thoughts beginning in the year 2000 to the present, as available for each dataset. The report must emphasize individuals in the highest categories of risk of death by suicide, specifically addressing the following characteristics: the age of the individual; the gender of the individual; and the individual's veteran status. The data must be disaggregated by county and recognized categories of risk, where available. The bill also calls for the summary report to contain all Texas policies and programs adopted across state systems to prevent suicides, as well as all state statutes addressing the topic.

This summary report addresses the call for action in H.B. 3980 by cataloging available data, state laws, and an inventory of state policies and programs from 2000 to the present. Highlighted in the report are data related to deaths by suicide in Texas including suicide mortality data, as is available as of January 1, 2020. Available years of data varies by source. The Centers for Disease Control and Prevention (CDC) had 2017 data available, while the Department of State Health Services (DSHS) had only finalized 2016 data. The U.S. Veteran's Administration only had data available back to 2004, instead of 2000, as required by H.B. 3980., through 2017.

The report also includes suicide attempt data, referenced as suicide morbidity data. One way to capture suicide morbidity data is by examining hospital discharges reported in Texas, specifically looking at hospitalizations due to suicide attempt. Hospital Discharge data was available to 2018. Since Hospital Discharge data does not capture all suicide attempts, emergency department visits for suicide attempt and calls to the poison control network for suspected suicide are also examined in this report. Emergency Department data was available to 2018 as was Poison Control Network data. Emergency Department data collection only began in 2016, while Poison Control Network data began in 2004.

The data section of the report includes data from the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System including

suicide attempt and suicidal thoughts among the adult population and high school students in Texas, respectively.

Lastly, the report lists statutes passed by the Texas Legislature concerning suicide from the 78th to the 86th Texas Legislative Sessions. This information is followed by a list of funding appropriated and programs implemented by state agencies since 2000 to combat suicide. This includes the agencies' policies regarding suicide.

2. Background

In Texas, a person dies by suicide approximately every two hours. In 2017, nearly 3,800 Texans lost their lives to suicide.[i] According to the CDC, suicide rates in Texas have increased 18.9 percent since 1999.[ii] This increase has led to suicide becoming the second leading cause of death for individuals 15-34 years old, the fourth leading cause of death for individuals 35-54 years old, and the eleventh leading cause of death across all age groups. More than twice as many people died by suicide in 2017 than in alcohol-related motor vehicle accidents.[iii]

When a person dies by suicide, there is an undeniable impact felt through that individual's social circle and the community. Suicide bereaved or loss survivors, those left behind after a suicide, are often plagued with complicated grief reactions, post-traumatic stress, and other major life disruptions following a loved one's suicide. Loss survivors are at a greater risk of attempting and dying by suicide themselves; therefore, providing support and treatment is imperative. According to the American Association of Suicidology Past-President, Julie Cerel's research, there are approximately 18 loss survivors for each suicide.[iv] This means there would be 68,400 loss survivors in Texas from 2017 suicides alone. More people are becoming loss survivors because of the increasing rates of suicide in the state each year.

In addition to the social impact, the financial impact of suicide is substantial. According to the American Foundation of Suicide Prevention (AFSP), Texas lost an estimated $3,516,245,000 in lifetime medical and work loss cost related to suicide in 2010. The cost averages to $1.2 million in financial loss per suicide death.[v]

The numbers and rate of suicide attempts have also continued to rise over the last several years. According to AFSP, the United States experienced approximately three times as many suicide attempts in 2017 as completed suicides. It is estimated Texas had approximately 11,400 suicide attempts in 2017; however, data later in this report will show that number has now nearly doubled. Individuals who attempt suicide are at high risk for dying by suicide in the future; therefore, it is critical for these individuals to receive follow-up care and treatment as suicide is preventable.

3. Suicide Data in Texas

Mortality Data

Mortality rates are calculated by dividing the number of deaths by the population and multiplying by 100,000. With a population of 29 million people, Texas has both the second largest state population and the second highest number of suicide deaths in the United States.[vi] While Texas was ranked 40th in the nation for suicide mortality rates in 2017,[vii] the state has experienced an increase in suicide mortality in the years since 2000. The crude death rate[viii] rose 35.7 percent, from 9.8 deaths per 100,000 population in 2000 to 13.3 deaths per 100,000 population in 2017.[ix] The increase was reflected to differing degrees by different groups within the population.

Age[1]

Adults aged 55-64 saw the greatest increase in suicide mortality of any age group from 2000 to 2017. During this timeframe, there was a 60.9 percent increase from a rate of 11.5 deaths per 100,000 population to a rate of 18.5 deaths per 100,000 population.

The increase for adults aged 25-34 was 47.4 percent, with rates rising from 11.6 deaths per 100,000 population to 17.4 deaths per 100,000 population.

Individuals aged 15-24 had the next highest increase at 41.1 percent, with rates rising from 10.7 deaths per 100,000 population to 15.1 deaths per 100,000 population.

The rate for children ages 5-14, while extremely low, experienced an increase of 30 percent, rising from 1.0 deaths per 100,000 population to 1.3 deaths per 100,000 population.

The rates for adults aged 65-74 increased 28.2 percent, rising from 11.7 deaths per 100,000 population to 15.0 deaths per 100,000 population and the rates for adults aged 35-44 increased 22.7 percent, rising from 13.2 deaths per 100,000 population to 16.2 deaths per 100,000 population.

[1]See Table 57, Table 58, and Table 59 in Appendix A

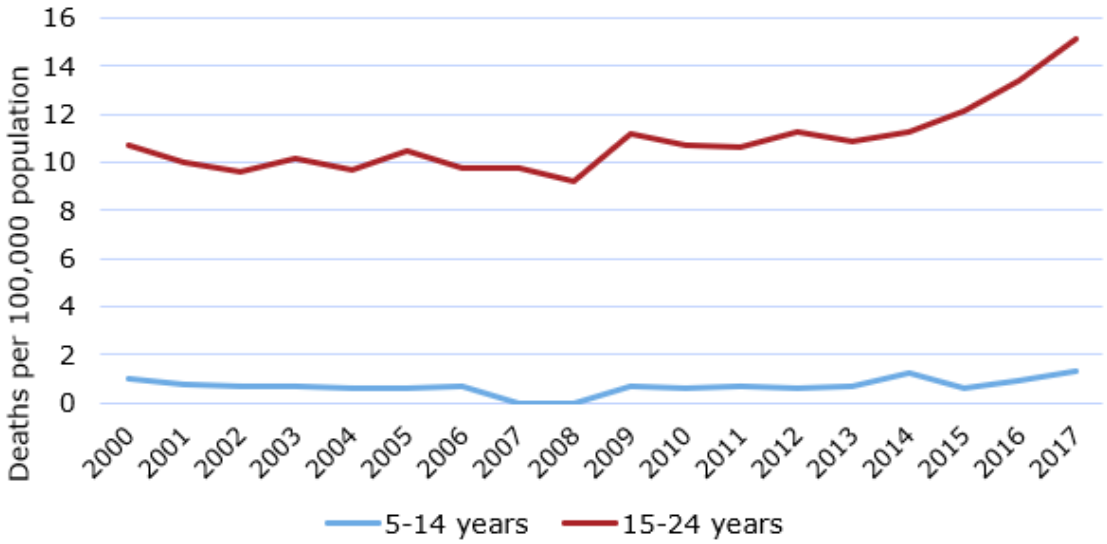
Individuals aged 45-54 saw a 19.5 percent increase from a rate of 14.9 deaths per 100,000 population to a rate of 17.8 deaths per 100,000 population.

Adults aged 75-84 saw the smallest increase at 4.2 percent, rising from 16.8 deaths per 100,000 population to 17.5 deaths per 100,000 population and the 84+ age group, which saw strong fluctuations in its rate, experienced the only decrease, lowering by 5 percent from 20.2 deaths per 100,000 population to 19.2 deaths per 100,000 population.

It is important to keep in mind that despite the fact the older age groups have the highest rates, the majority of suicides occur in middle age.

Figure 1 outlines the suicide mortality rate by youth and young adults from 2000-2017.

Figure 1. Youth and Young Adult Suicide Mortality, Texas 2000-2017[2]



[2] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Figure 2 outlines the suicide mortality rate by individuals in their middle years from 2000-2017.

Figure 2. Suicide Mortality in the Middle Years, Texas 2000-2017[5]

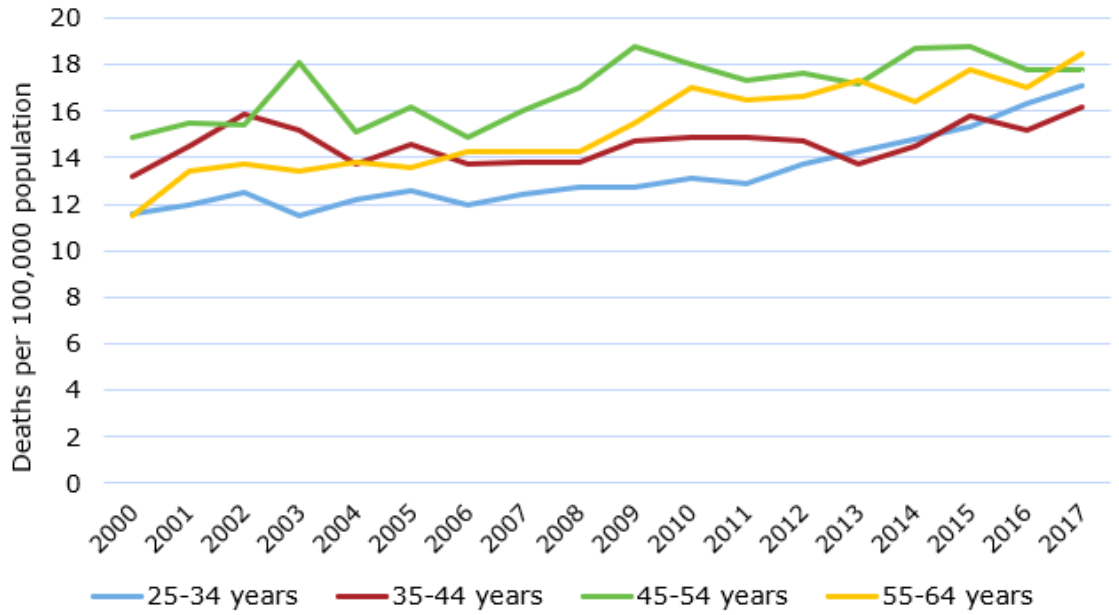
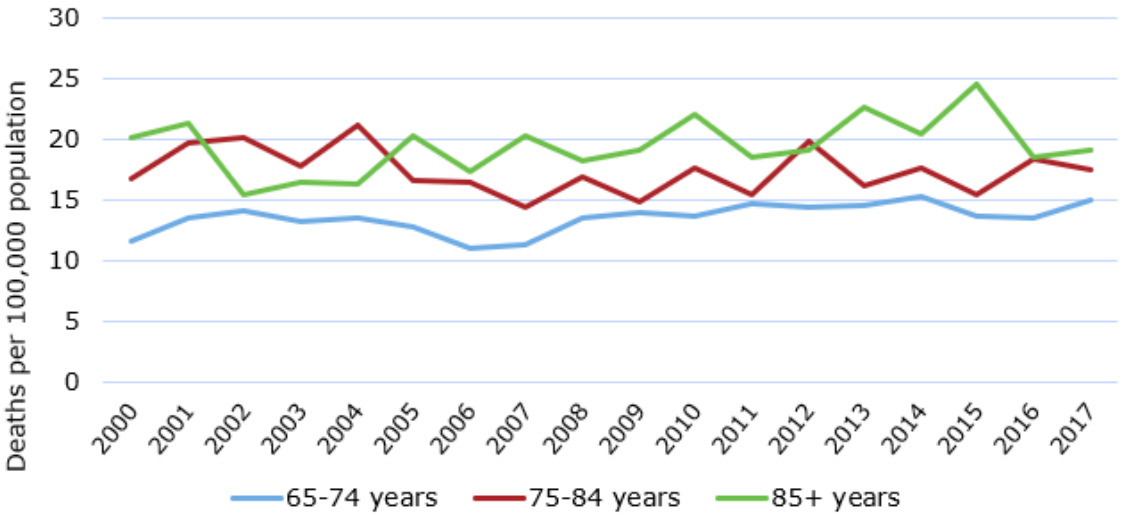


Figure 3 outlines the suicide mortality rate by older Texans from 2000-2017.

Figure 3. Suicide Mortality in Older Texas Residents[3]



[3] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Race and Ethnicity[4]

Changes in suicide mortality rates also varied by race and ethnicity from 2000-2017. Texas residents of Asian or Pacific Island descent had the largest increase in rate at 75 percent, increasing rates from 4.0 deaths per 100,000 population to 7.0 deaths per 100,000 population between 2000 and 2017.

The next highest increase was among white and non-Hispanic Texas residents whose rate increased 55.1 percent from 13.8 deaths per 100,000 population to 21.4 deaths per 100,000 population.

Black or African American Texas residents saw a 39.3 percent increase from a rate of 5.6 deaths per 100,000 population to 7.8 deaths per 100,000 population, with the increase occurring mostly after 2014.

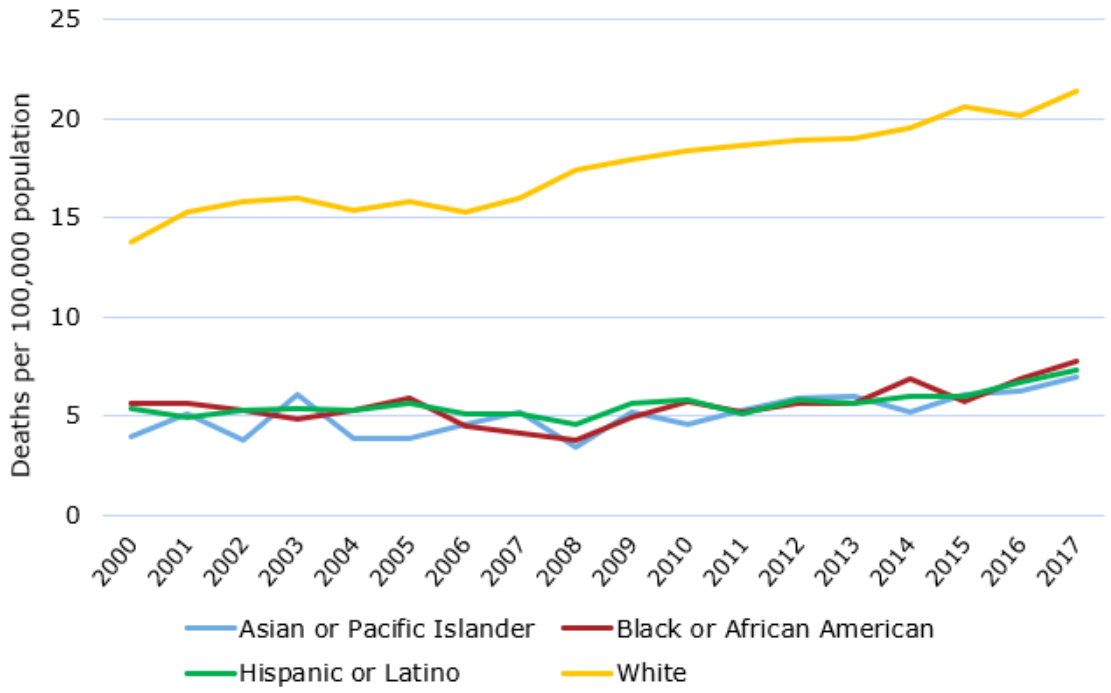
Texas residents of Hispanic or Latino ethnicity saw a 35.2 percent rate increase of 5.4 deaths per 100,000 population to 7.3 deaths per 100,000 population.

There were 87 suicide deaths among the American Indian or Alaskan Native race group during the 18 years of analysis, producing an overall crude mortality rate of 2.0 deaths per 100,000 population. There was not a single year in the 18-year period with more than 9 suicide deaths in that population to produce an unreliable suicide death rate or greater than 20 to produce a reliable suicide death rate.

[4] See Table 60 in Appendix A

Figure 4 outlines suicide mortality by race and ethnicity for 2000-2017.

Figure 4. Suicide Mortality by Race and Ethnicity, Texas 2000-2017[5]



Sex[6]

Suicide mortality rates vary by sex to a large degree. Males are three to four times as likely to die by suicide as females in the state of Texas; however, rates among females increased slightly more than males between 2000 and 2017.

Rates for females increased by 50 percent, from 3.8 deaths per 100,000 population to 5.7 deaths per 100,000 population.

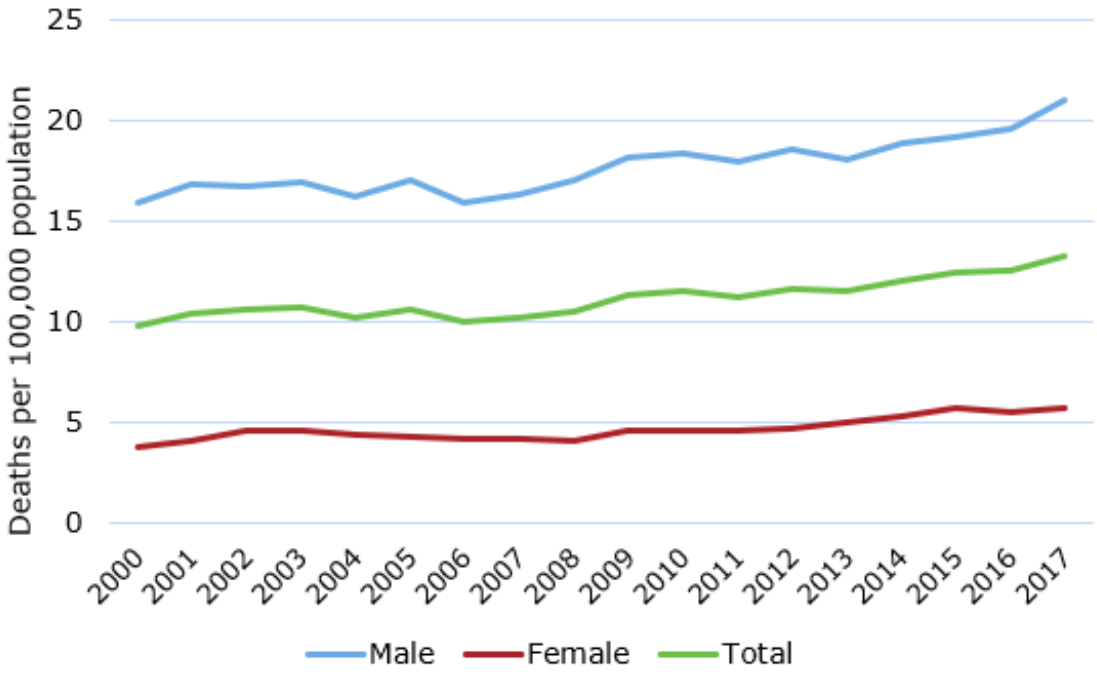
Rates for males increased 32.1 percent, from 15.9 deaths per 100,000 population to 21 deaths per 100,000 population.

[5] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

[6] See Table 61, Table 62, and Table 63 in Appendix A

Figure 5 outlines the suicide mortality rate by sex for 2000-2017.

Figure 5. Suicide Mortality by Sex, Texas 2000-2017[7]



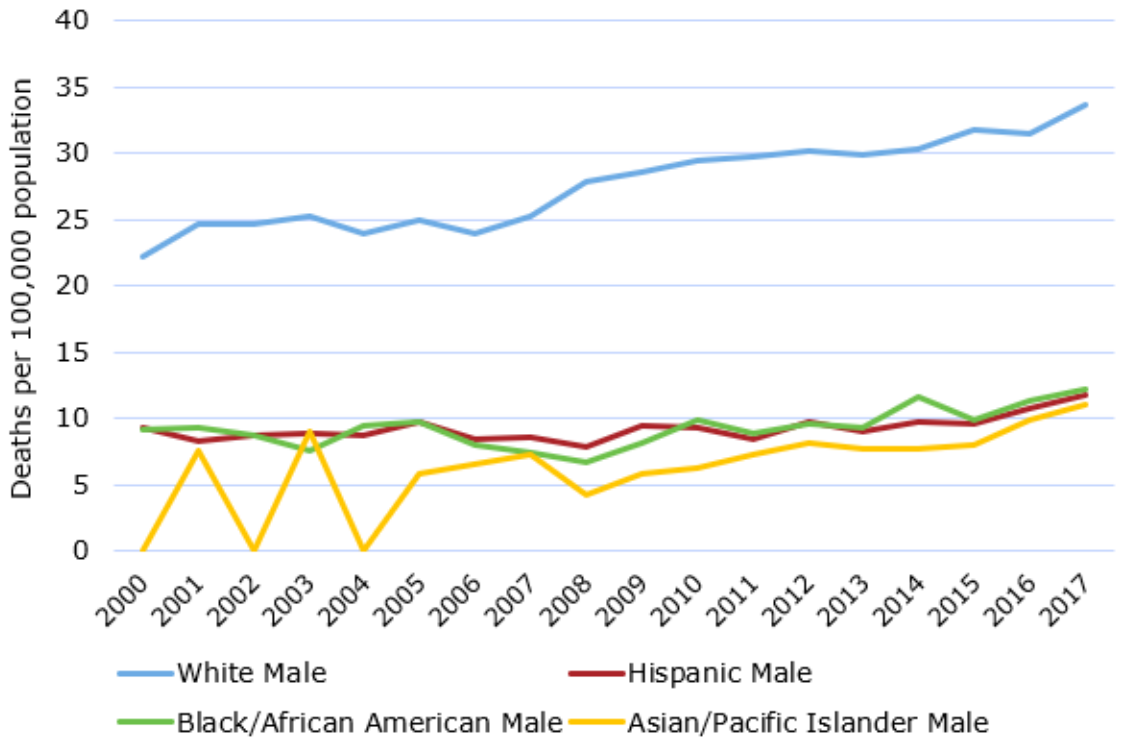
Mortality rates vary further by race and ethnicity and sex. Among both males and females, whites have the highest suicide mortality rate. Rates are increasing among all groups, but to different degrees.

White male suicide mortality rates have increased by 51.8 percent from 22.2 deaths per 100,000 population to 33.7 deaths per 100,000 population. Black or African American male suicide mortality rates have increased by 32.6 percent from 9.2 deaths per 100,000 population to 12.2 deaths per 100,000 population and the increase mostly occurred in the years after 2014. The rates among Asian or Pacific Islander males have increased the most at 48 percent from 7.5 deaths per 100,000 population to 11.1 deaths per 100,000 population. The rates among Hispanic males have increased 25.8 percent from 9.3 deaths per 100,000 population to 11.7 deaths per 100,000 population.

[7] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Figure 6 outlines the male suicide mortality rate by race and ethnicity for 2000-2017.

Figure 6. Male Suicide Mortality by Race and Ethnicity, Texas 2000-2017[8]



Female suicide mortality rates by race and ethnicity group are increasing at a higher rate than male suicide mortality rates by race and ethnicity group. The white females suicide mortality rate increased 61.4 percent between 2000 and 2017 from 5.7 deaths per 100,000 population to 9.2 deaths per 100,000 population.

The Hispanic female suicide mortality rate increased 123.1 percent from 1.3 deaths per 100,000 population to 2.9 deaths per 100,000 population.

The black or African American female suicide mortality rate increased by 68.2 percent from 2.2 deaths per 100,000 population to 3.7 deaths per 100,000 population.

The rate for Asian or Pacific Islander females was unreliable due to small numbers (<20 deaths per year) and could not reliably be measured.

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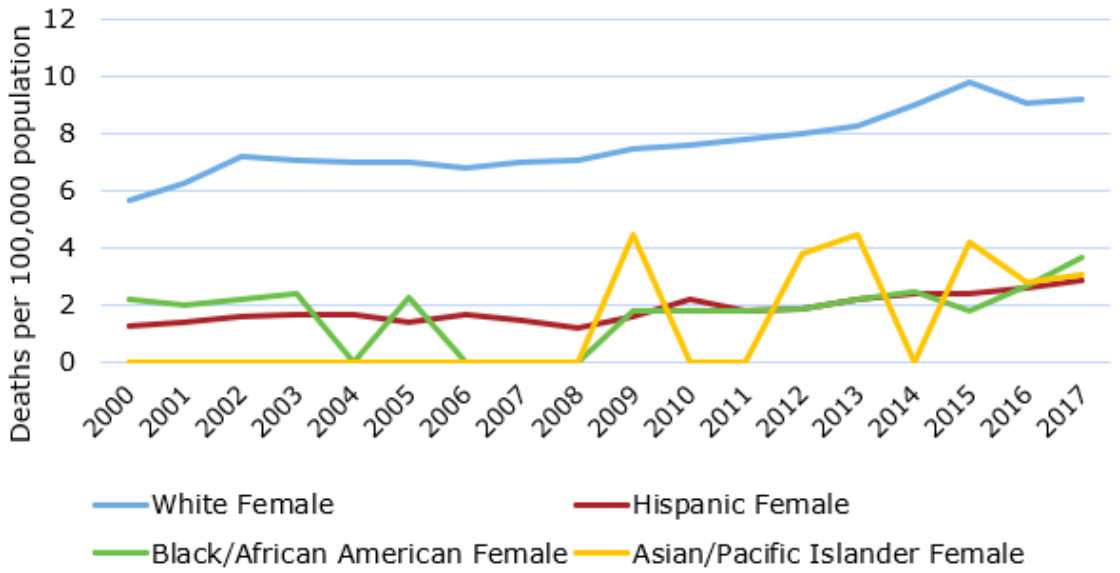
[8] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Figure 7 outlines the female suicide mortality rate by race and ethnicity for 2000-2017.

Figure 7. Female Suicide Mortality by Race and Ethnicity, Texas 2000-2017[9]



Veterans[10]

Veterans had a higher death rate by suicide than most of the other categories examined in this report with a rate approximately two times higher than the overall Texas rate. The veteran suicide death rate rose 32 percent between 2005 and 2017, from 23.8 deaths per 100,000 veteran population to 31.3 deaths per 100,000 veteran population.

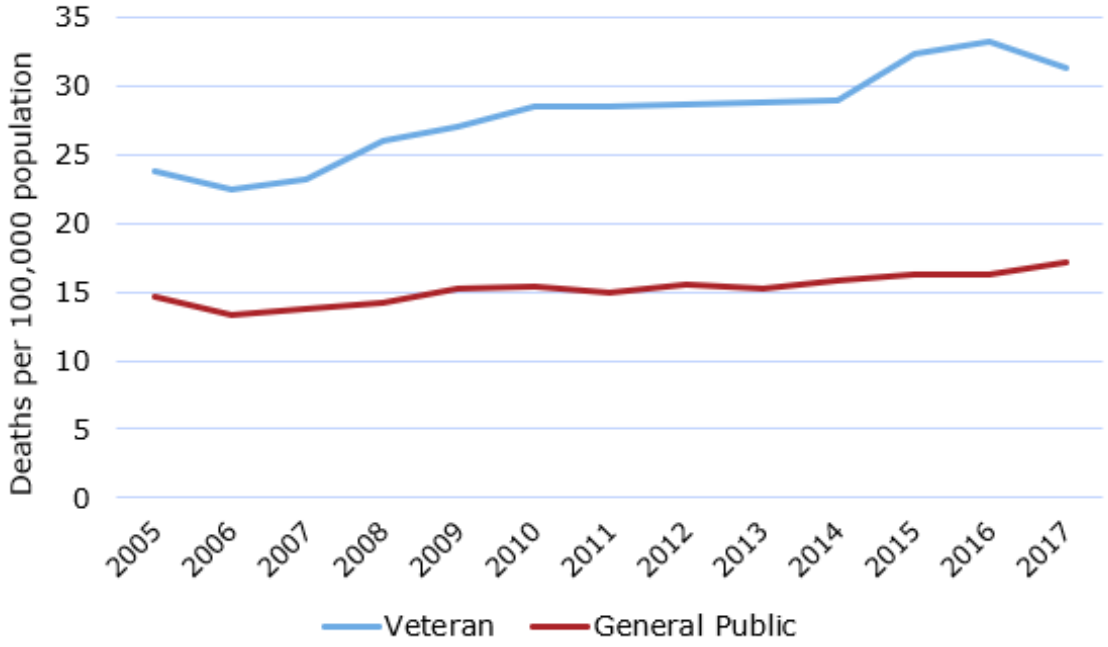
The rate of veteran suicide mortality decreased in 2017, but it is too soon to confirm the decrease as a trend. At least one more year of decreasing rates is needed to show that the 2017 rate is not an anomaly. Due to the method of collecting information on the death certificate, it was not possible to calculate rates for active duty service members in Texas.

[9] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

[10] See Table 64 in Appendix A

Figure 8 outlines the age-adjusted suicide mortality rate for veterans and the general public for 2005-2017.

Figure 8. Age-Adjusted[11] Suicide Mortality, Veterans and General Public, Texas 2005-2017[12]



[11] Age-adjusted mortality rate is the rate that would have existed if both compared populations had the same age distribution. It is frequently used when populations have disparate age distributions.

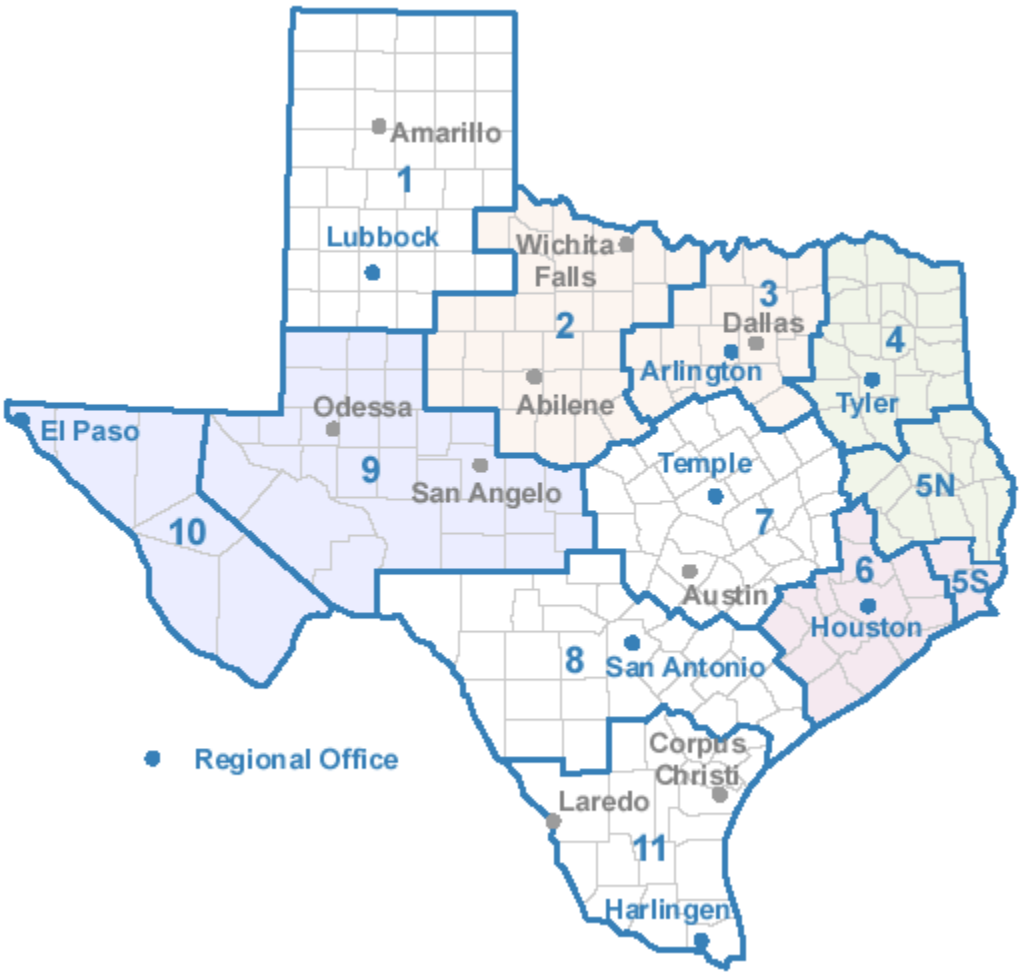
[12] US Veteran's Administration

Public Health Regions[13]

The highest rates of suicide mortality over the 17 years of available data occurred in Public Health Regions (PHR) 4, 2, 5, and 1. The statewide rate for the 17-year period was 11.1 deaths per 100,000 population, while the rate for Region 4 was 16.2 deaths per 100,000 population. The rate for Region 2 was 14.8 deaths per 100,000 population, the rate for Region 5 was 14.2 deaths per 100,000 population, and the rate for Region 1 was 13.8 deaths per 100,000 population.

Figure 9 outlines the map of Public Health Regions (PHR)

Figure 9. Map of Public Health Regions[14]



[13] See Table 65, Table 66, and Table 67 in Appendix A

[14] Department of State Health Services

Region 5 saw the smallest increase over the 17-year period with an increase of 2.9 percent from 14.0 deaths per 100,000 population to 14.4 deaths per 100,000 population.

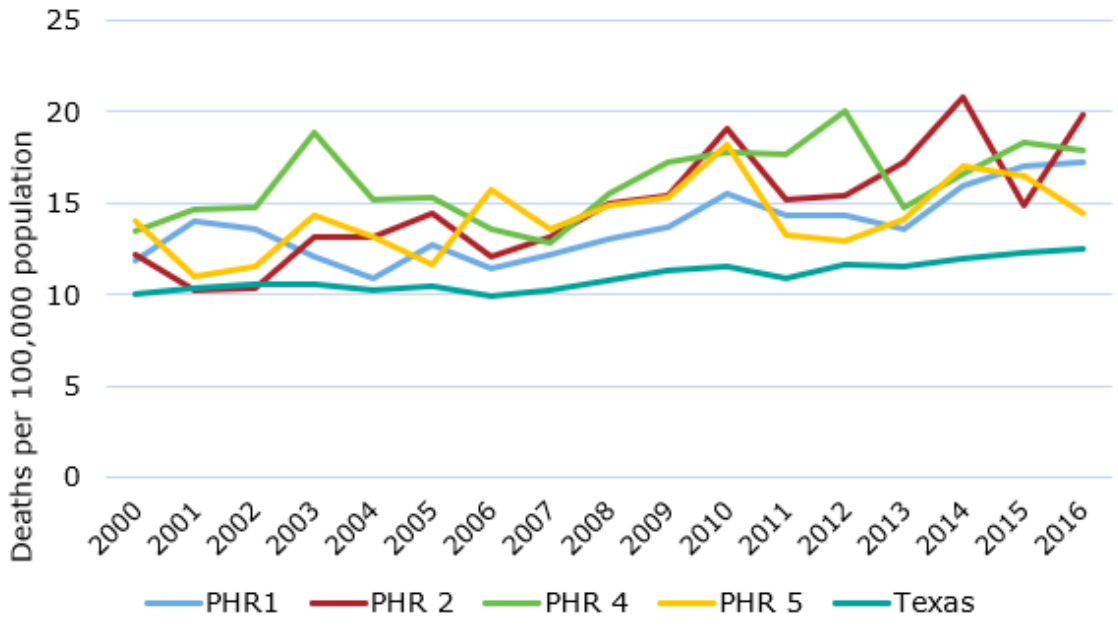
Region 2 saw the largest increase over the 17-year period with an increase of 62.3 percent, from 12.2 deaths per 100,000 population to 19.8 deaths per 100,000 population.

Region 1 saw the second largest increase with an increase of 44.5 percent, from 11.9 deaths per 100,000 population to 17.2 deaths per 100,000 population.

Region 4 saw a large increase of 32.6 percent, from 13.5 deaths per 100,000 population to 17.9 deaths per 100,000 population. Because data from Department of State Health Services was used for the Public Health Region analysis, the data only extends to 2016, which was their most recently finalized data.

Figure 10 outlines the suicide mortality rate by PHR per 100,000 population for 2000-2016.

Figure 10. Suicide Mortality with Rates Higher than State Rate by Public Health Region (PHR), 2000-2016[15]



[15] Texas Death Certificate Data, Prepared by: Texas Department of State Health Services, Center for Health Statistics

Looking at the 17-year mortality rates, Region 11 and Region 10's suicide mortality rates were well below the state rate with rates of 7.3 deaths per 100,000 population and 8.0 deaths per 100,000 population, respectively.

Region 3 and Region 6's rates were also below the state rate with rates of 10.5 deaths per 100,000 population and 10.6 deaths per 100,000 population.

Region 3 experienced the largest suicide mortality rate increase of 36 percent, with rates rising from 8.9 deaths per 100,000 population to 12.1 deaths per 100,000 population.

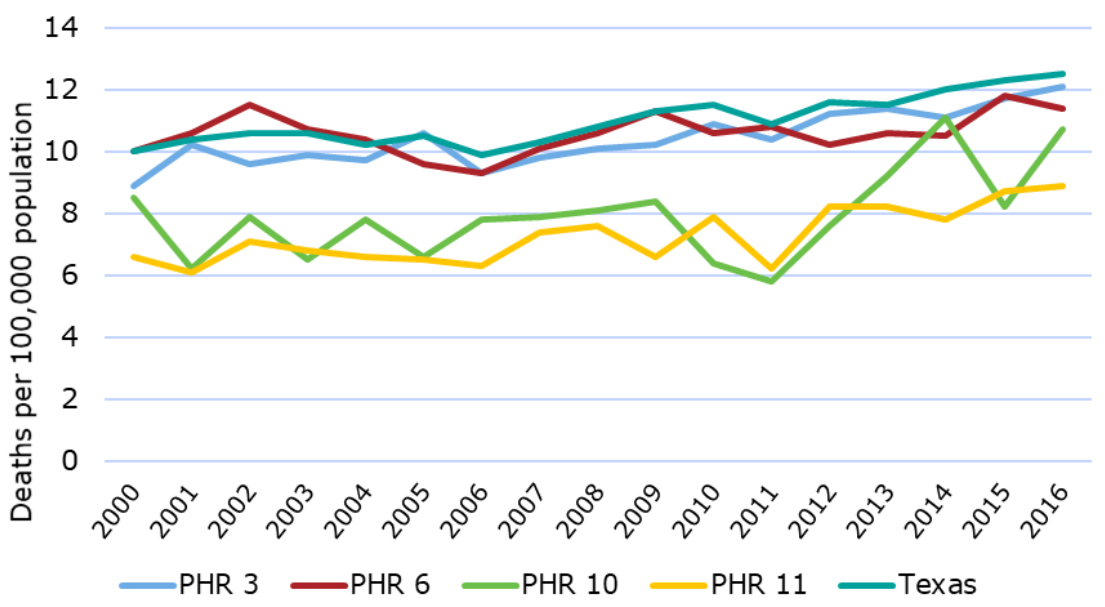
Region 11 saw a similar increase of 34.8 percent with an increase from 6.6 deaths per 100,000 population to 8.9 deaths per 100,000 population.

Region 10 saw the next highest increase of 25.9 percent with rates rising from 8.5 deaths per 100,000 population to 10.7 deaths per 100,000 population.

Region 6 saw the smallest increase for this group with an increase of 14 percent, rising from 10.0 deaths per 100,000 population to 11.4 deaths per 100,000 population.

Figure 11 outlines mortality rates by PHR compared to the state rate for 2000-2016.

Figure 11. Suicide Mortality with Rates Lower than State Rate by Public Health Region (PHR), 2000-2016[16]



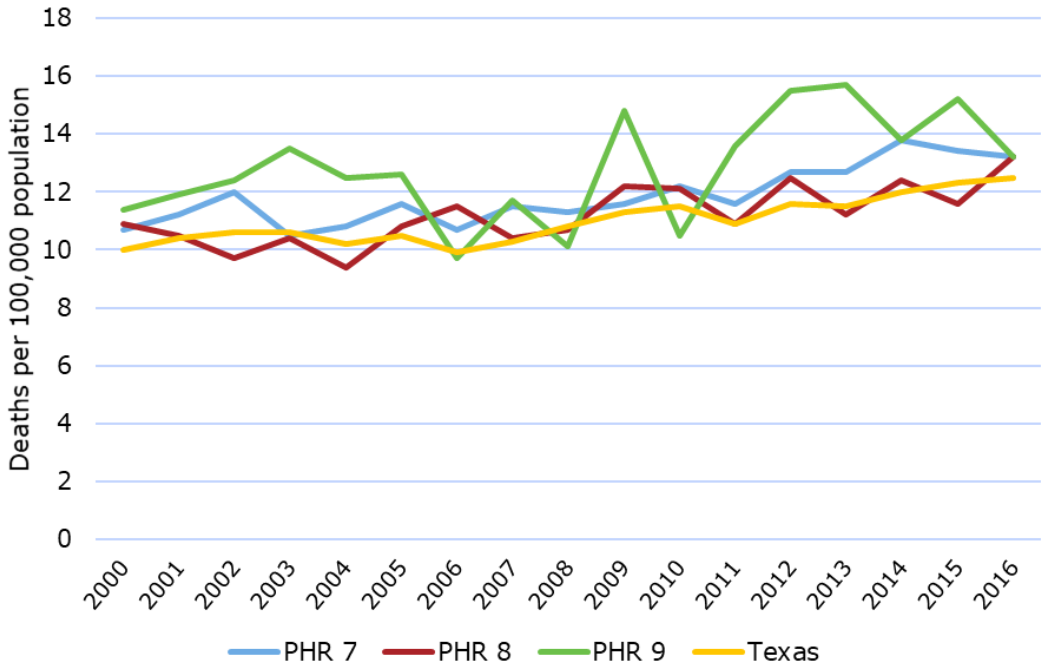
Region 7, Region 8, and Region 9 had suicide mortality rates for the 17-year period similar to the state rate. The rate for Region 7 was 11.9 deaths per 100,000 population, for Region 8 it was 11.3 deaths per 100,000 population, and for Region 9, it was 12.9 deaths per 100,000 population.

These regions also experienced modest increases in annual rates over the 17-year period. Region 7's rate increased by 23.4 percent, from 10.7 deaths per 100,000 population to 13.2 deaths per 100,000 population, Region 8's rate increased by 21.1 percent, from 10.9 deaths per 100,000 population to 13.2 deaths per 100,000 population and Region 9's increased by 15.8 percent, from 11.4 deaths per 100,000 population to 13.2 deaths per 100,000 population.

[16] Texas Death Certificate Data, prepared by: Texas Department of State Health Services, Center for Health Statistics

Figure 12 outlines suicide mortality rates by PHR similar to the state rate for 2000-2016.

Figure 12. Suicide Mortality with Rates Similar to the State Rate by Public Health Region (PHR), 2000-2016[17]



Snapshot of Public Health Regions

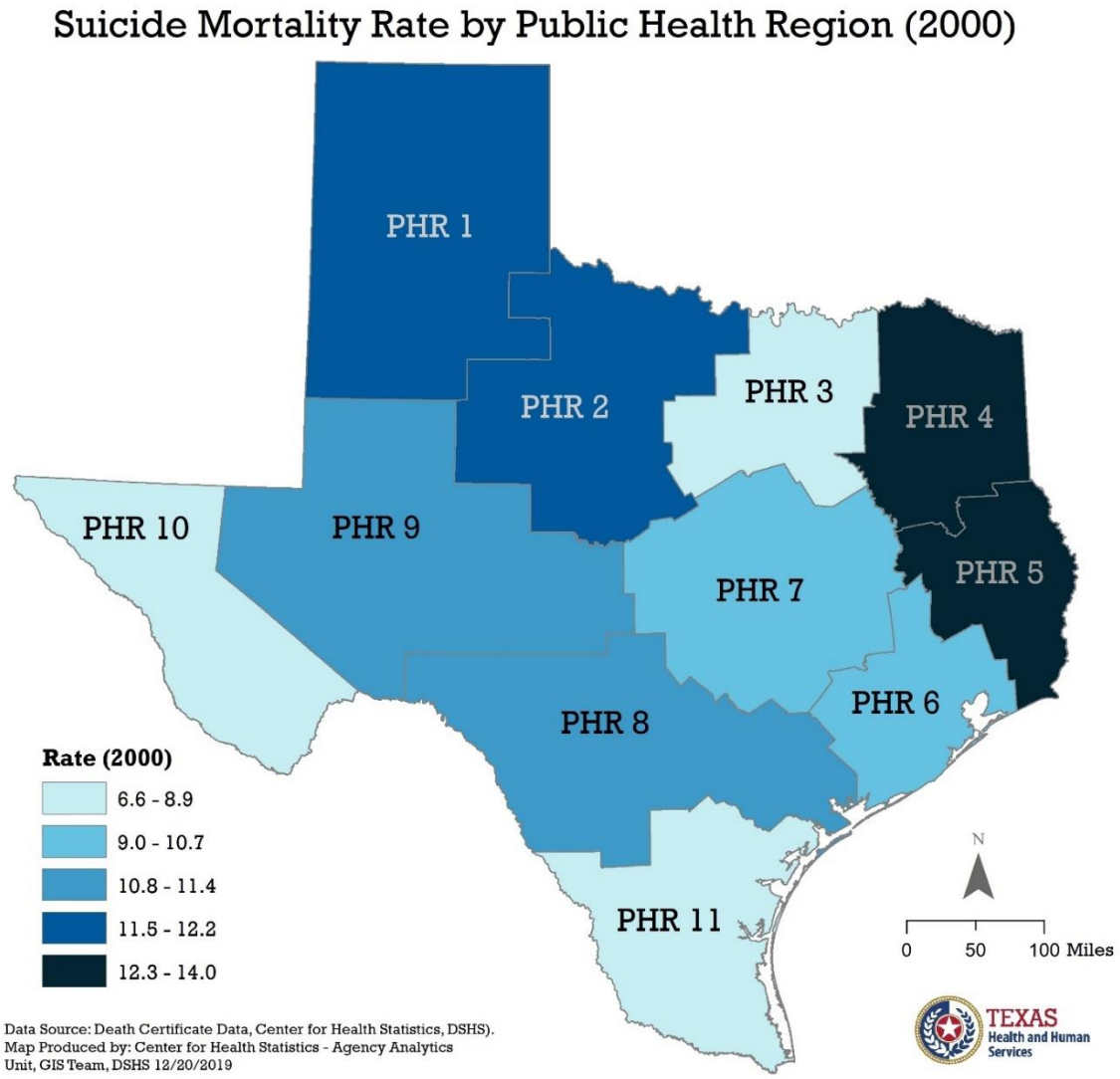
The next three pages provide maps of the mortality rate (per 100,000 population) for Public Health Regions providing a snapshot in time to compare the rates across regions. The first map shows the year 2000; the second shows 2008; and the third shows 2016, the most recent available data by PHR.

In 2000, the highest rate of suicide mortality was in Public Health Region 5, with a rate of 14.0 deaths per 100,000 population. Public Health Region 4 had a similarly high rate of 13.5 deaths per 100,000 population. The lowest rates were in Public Health Region 11 with a rate of 6.6 deaths per 100,000 population and Public Health Regions 10 and 3 with rates of 8.5 deaths per 100,000 population and 8.9 deaths per 100,000 population respectively. The state rate was 10.0 deaths per 100,000 population.

[17] Texas Death Certificate Data, prepared by: Texas Department of State Health Services, Center for Health Statistics

Figure 13 outlines the suicide mortality rates per 100,000 by PHR in 2000.

Figure 13. Suicide Mortality Rates per 100,000 Population by Public Health Region, Texas 2000[18]

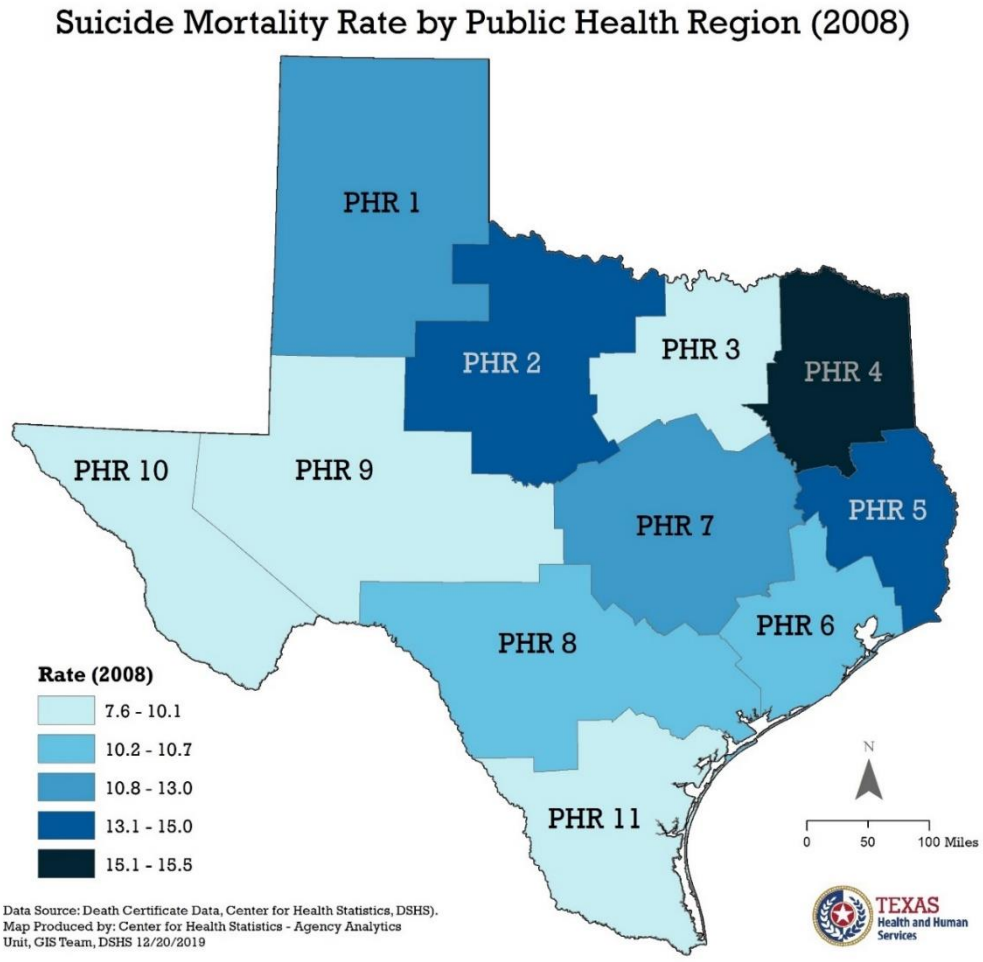


In 2008, Public Health Region 4 still had the highest rate at 15.5 deaths per 100,000 population. Regions 2 and 5 had similar rates at 15.0 deaths per 100,000 population and 14.9 deaths per 100,000 population, respectively. The lowest rates were in Region 11 with 7.6 deaths per 100,000 population and Public Health Region 10 with 8.1 deaths per 100,000 population. The state rate was 10.8 deaths per 100,000 population.

[18] Death Certificate Data, Center for Health Statistics, Department of State Health Services

Figure 14 outlines the suicide mortality rates per 100,000 population by PHR in 2008.

Figure 14. Suicide Mortality Rates per 100,000 Population by Public Health Region, Texas 2008[19]

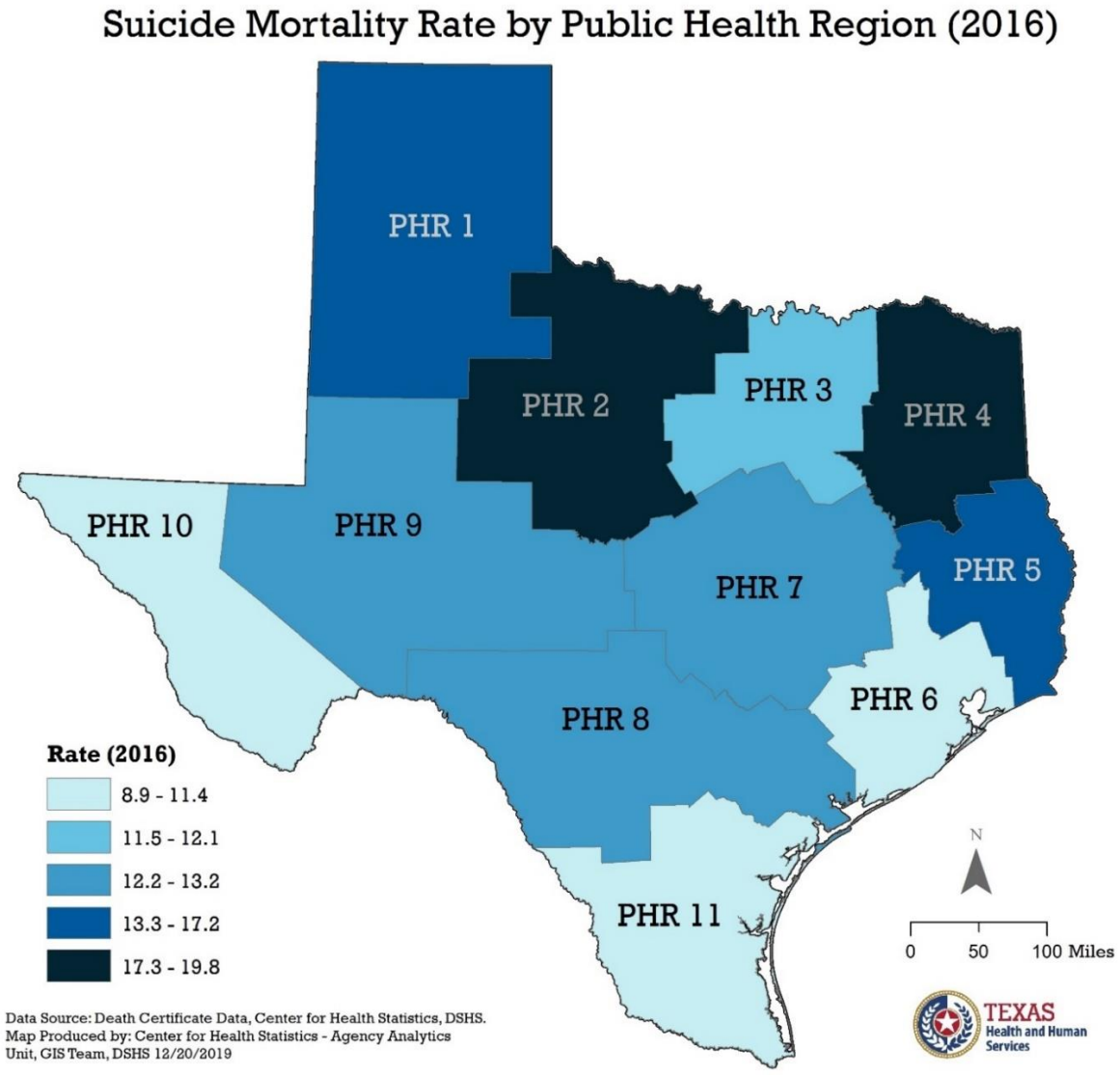


In 2016, the highest rate was in Public Health Region 2 with a rate of 19.8 deaths per 100,000 population. Public Health Regions 4 and 1 had similarly high rates of 17.9 deaths per 100,000 population and 17.2 deaths per 100,000 population. The lowest rates were in Public Health Regions 11, 10, and 6 with rates of 8.9 deaths per 100,000 population, 10.7 deaths per 100,000 population, and 11.4 deaths per 100,000 population, respectively. The state rate was 12.5 deaths per 100,000 population.

[19] Death Certificate Data, Center for Health Statistics, Department of State Health Services

Figure 15 outlines the suicide mortality rates per 100,000 population by PHR in 2016.

Figure 15. Suicide Mortality per 100,000 Population by Public Health Region, Texas 2016[20]



[20] Death Certificate Data, Center for Health Statistics, Department of State Health Services

Metro and Non-Metro Areas[21]

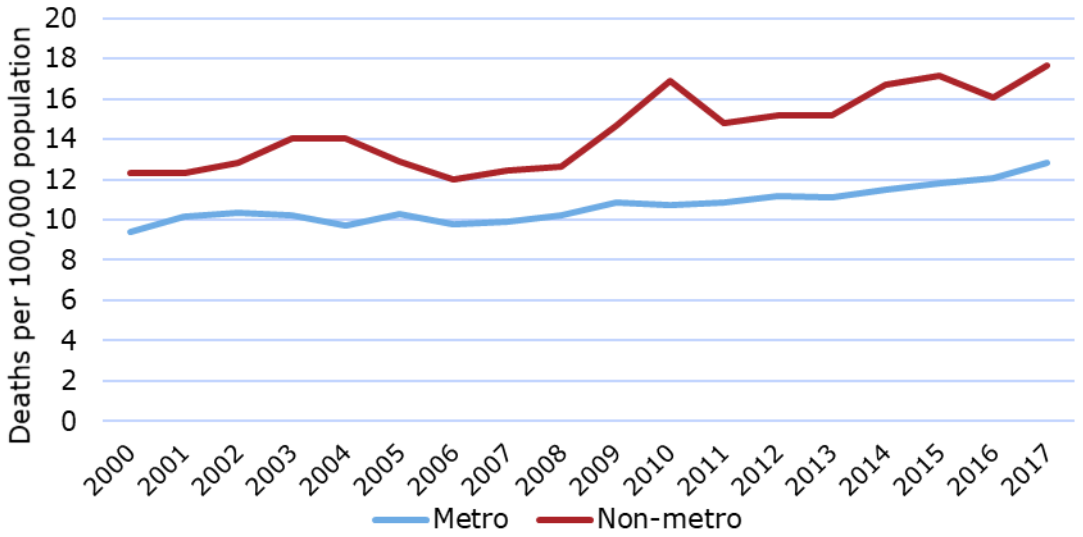
While the majority of suicide deaths in Texas occur in metro areas, the suicide mortality rate in non-metro areas is about 30-45 percent higher than the rate in metro areas. The mortality rate also increased by a higher percentage over the 18 years of data examined in this report. Suicide mortality in metro areas increased by 36 percent from 9.4 deaths per 100,000 population to 12.8 deaths per 100,000 population.

Suicide mortality in non-metro areas increased by 43 percent from 12.3 deaths per 100,000 population to 17.6 deaths per 100,000 population. Metro area is defined as being a county in a Metropolitan Statistical Area (MSA)[x]. There are 25 MSAs in Texas. They are: Dallas-Fort Worth-Arlington, Houston-The Woodlands-Sugarland, San Antonio-New Braunfels, Austin-Round Rock-San Marcos, McAllen-Edinburg-Mission, El Paso, Corpus Christi, Brownsville-Harlingen, Killeen-Temple-Fort Hood, Beaumont-Port Arthur, Lubbock, Laredo, Amarillo, Waco, College Station-Bryan, Tyler, Longview, Abilene, Wichita Falls, Texarkana, Odessa, Midland, Sherman-Denison, Victoria, and San Angelo.

[21] See Table 68 in Appendix A

Figure 16 outlines the suicide mortality rate by metro and non-metro areas for 2000-2017.

Figure 16. Suicide Mortality Rate by Metro and Non-Metro Areas, Texas 2000-2017[22]



Counties[23]

In order to calculate rates for the greatest proportion of all counties in Texas, 18-year rates were calculated to compare among counties. Any time there are fewer than ten deaths from a particular cause in an area, the number is suppressed to protect the descendent. If there are fewer than 20 deaths, any rate calculated is considered unstable. Many counties still did not have enough suicide deaths over the 18-year period to calculate a stable rate. The highest reliable rates were in Haskell (24.6), Jones (23.4), Aransas (22.5), Marion (22.4), Stephens (22.2), Montague (21.9), Somervell (21.3), Anderson (21.1), Carson (20.4), Tyler, (20.4), Fannin (20.2), Van Zandt (20.2), Palo Pinto (20.2), Blanco (19.9), Polk (19.9), and Bandera (19.6). The lowest reliable rates were in Hidalgo (5.1), Maverick (5.3), Webb (5.4), Willacy (5.5), Cameron (6.1), Starr (7.0), Frio (7.4), Brazos (7.7), Val Verde (7.7), El Paso (8.0), Fort Bend (8.0), Moore (8.6), Hale (8.9), Collin (9.4), Pecos (9.5), Dawson (9.6), Deaf Smith (9.7), Denton (9.7), Dallas (9.8), and Washington (9.8). (See table 17 in Appendix A for more details.)

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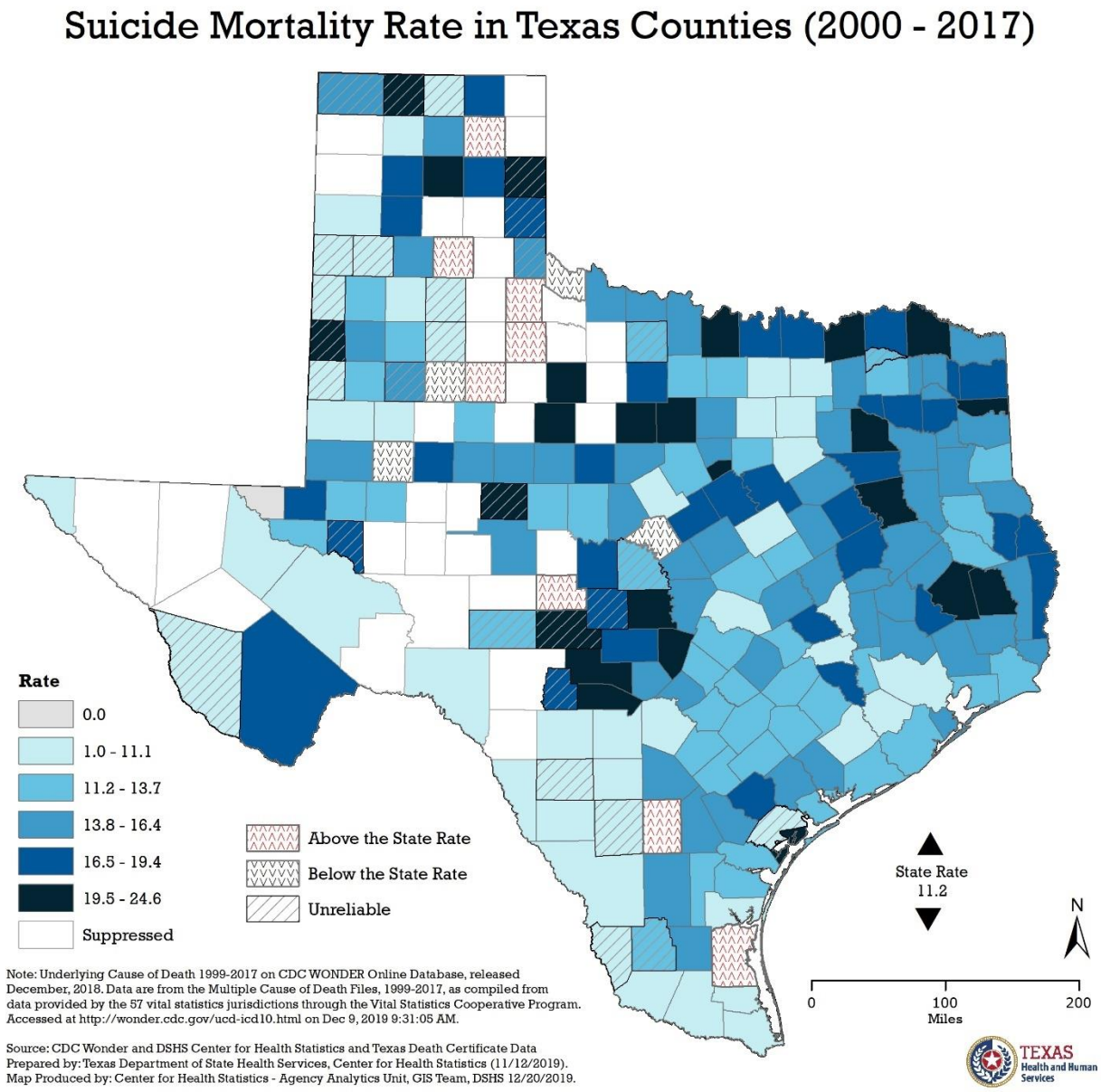
[22] National Center for Health Statistics, Centers for Disease Control and Prevention, WISQARS

[23] See Table 69 in Appendix A

Steps were taken to identify counties that clearly had a rate under or over the state rate by calculating a minimum and maximum rate possible. Utilizing the highest number of deaths that could be suppressed, which would be nine (9), as the maximum, and the lowest possible number of deaths knowing which three-year periods the county experienced no deaths by suicide and assuming that the county only experienced one death by suicide in the other suppressed three-year periods, as the lowest, probable rate ranges were calculated. Those counties that were either both above or both below the state rate in those full ranges are identified on the map. The counties identified as suppressed, had 9 or fewer deaths in the 18-year period and had small enough populations that the rate was both above and below the state rate given either the lowest possible number of suicides experienced, or the maximum number of suicides experienced. Attempting to estimate the rate was too unstable.

Figure 17 outlines the 18-year suicide mortality rates per 100,000 population in Texas Counties for 2000-2017.

Figure 17. 18-Year Suicide Mortality Rates per 100,000 population in Texas Counties, 2000-2017[24]



[24] National Center for Health Statistics, Center for Disease Control and Prevention, CDC WONDER and Center for Health Statistics, Department of State Health Services

Limitations of Mortality Data

Mortality data is only as accurate as the death certificates on which it is based. Suicide is underreported on death certificates and therefore underreported in mortality data.[xi] As mentioned previously, any number under 10 is suppressed to protect the confidentiality of the deceased and any number under 20 is not calculated into a rate, so small numbers make it difficult to estimate rates for some areas or some groups.

There is not a way to report transgender status on death certificates and sexual identity is not reported on death certificates. As a result, mortality data is not available for those two high-risk groups. There exist difficulties to calculate such rates because if the numbers were collected, the Texas demographer does not currently estimate population size for those groups. Therefore, there would not be a denominator for this population's suicide mortality data.

Texas death certificates contain a single item identifying the decedent as being associated with the military, not specifying duty status. The overall numbers of military associated deaths cannot be calculated into rates because it is unclear whether the denominator should be all veterans and active duty service members or just all veterans. Veteran specific mortality data were therefore obtained from the U.S. Veteran's Administration. Obtaining the same Texas specific data on current military service members was not an option.

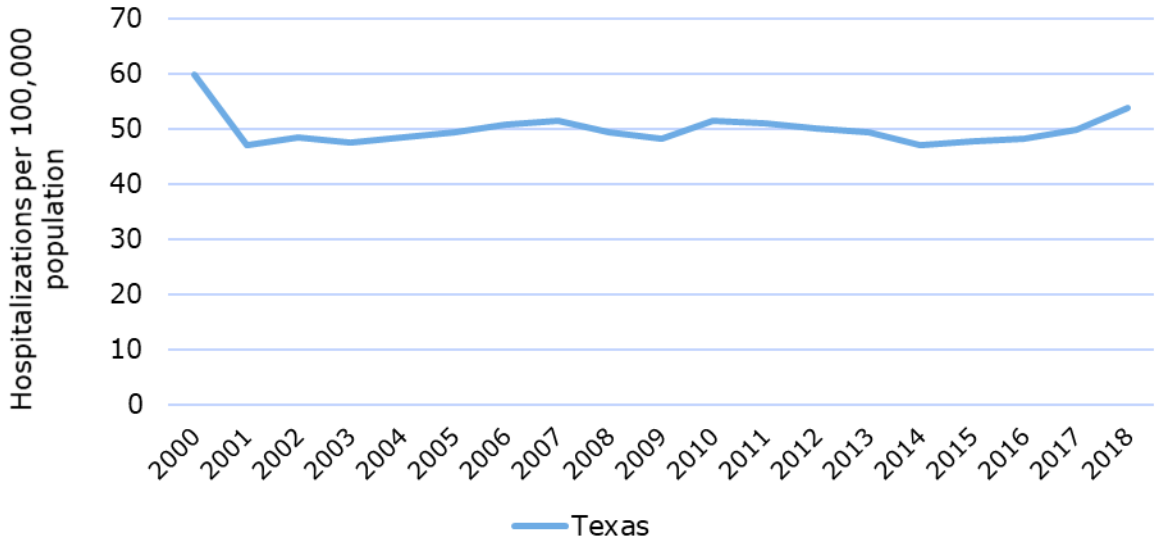
Hospitalization Data[25]

There are about 15,000 hospitalizations each year for suicide attempts in the state of Texas. The number of hospitalizations has been steadily increasing since 2001, but the population of Texas has also been growing, leading to a relatively small increase in the rate of hospitalizations due to suicide attempt. In 2001, the rate was 47.2 hospitalizations per 100,000 population and in 2018, the rate was 53.8 hospitalizations per 100,000 population representing a 14 percent increase overall.

[25] See Table 70 in Appendix A

Figure 18 outlines the hospitalization rate for suicide attempts in Texas from 2000-2018.

Figure 18. Hospitalization Rate for Suicide Attempt, Texas 2000-2018[26]



There is a noticeable spike in hospitalizations for suicide attempts in 2000 that is unexplainable. Social, weather, and economic events in Texas were examined to try to explain the spike, but no cause was concluded. Future data analysis will examine hospitalization for suicide attempts which occurred in the late 1990s to determine if the 2000 rate is a decrease from a previously higher rate. Because of this anomaly, all analysis of hospital discharge data begins with 2001.

Public Health Region[27]

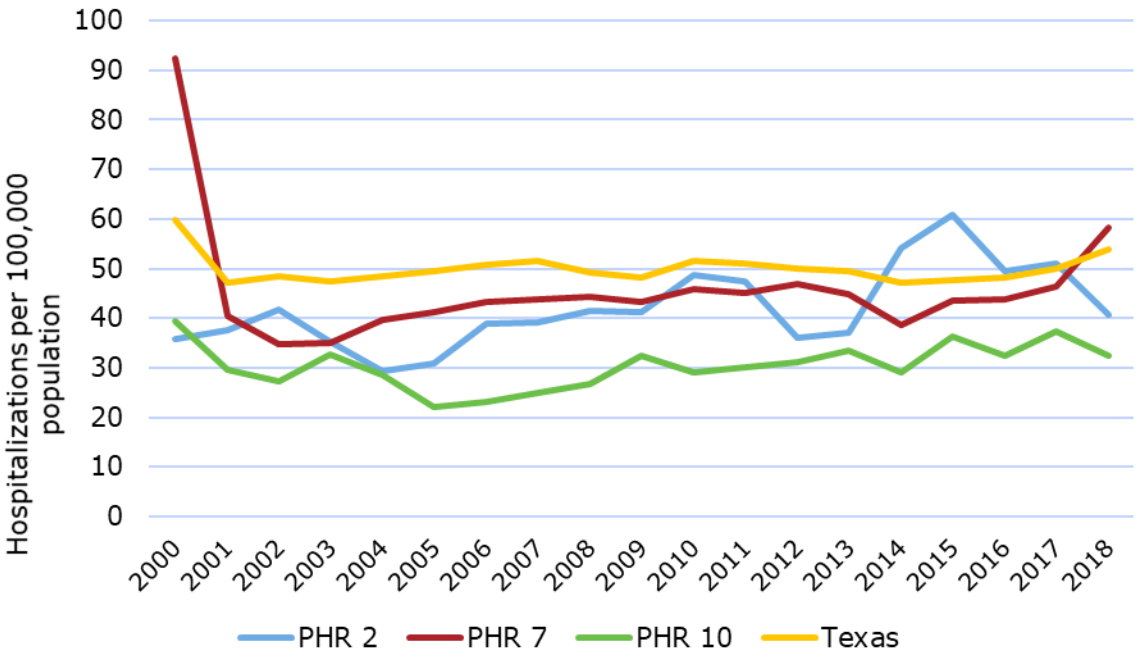
Public Health Regions 2, 7, and 10 have hospitalization for suicide attempt rates lower than the state rate. They had differing changes in rates over the period from 2001 and 2018. The hospitalization rate for suicide attempt in Region 2 increased by 35.6 percent, from 37.6 hospitalizations per 100,000 population to 50.9 hospitalizations per 100,000 population. The rate in Region 7 increased by 15.1 percent, from 40.3 hospitalizations per 100,000 population to 46.4 hospitalizations per 100,000 population. And the rate in Region 10 increased by 26.6 percent, from 29.6 hospitalizations per 100,000 population to 37.4 hospitalizations per 100,000 population.

[26] Texas Health Care Information Collection (THCIC), Department of State Health Services

[27] See Table 71, Table 72, and Table 74 in Appendix A

Figure 19 outlines the hospitalization for suicide attempt rates below the state rates by PHR from 2000-2018.

Figure 19. Hospitalization for Suicide Attempt Rates Below the State Rates by Public Health Region (PHR), 2000-2018[28]

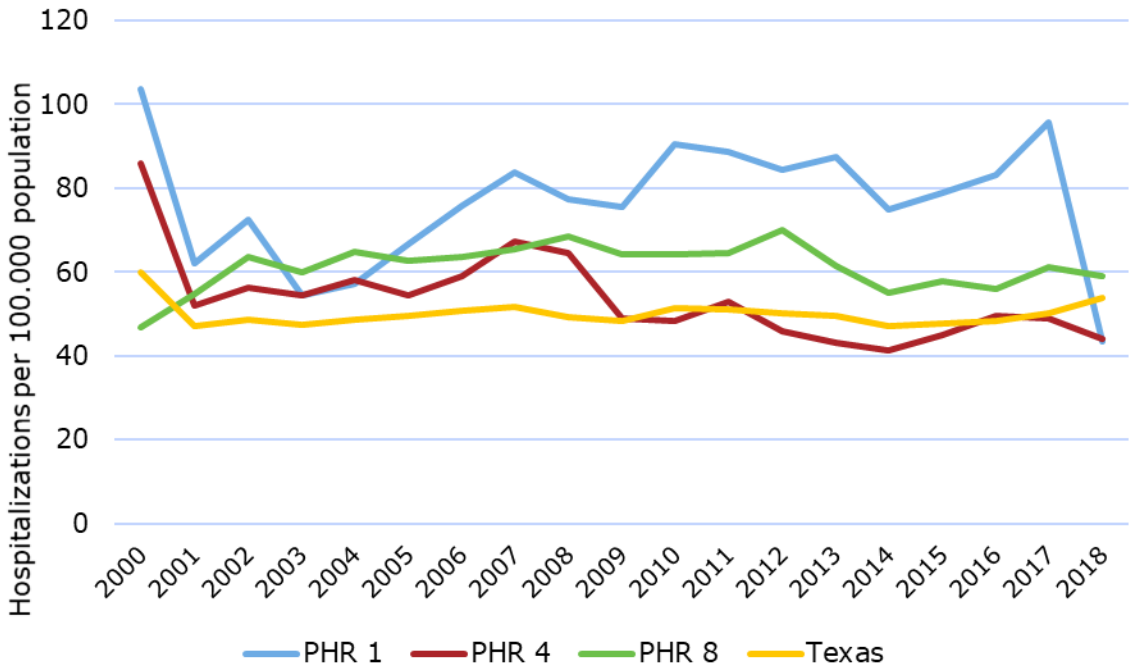


Public Health Regions 1, 4, and 8 all have rates above the state rate. They too have differing changes in rates between 2001 and 2017. The rate in Region 1 increased by 54.6 percent, from 61.9 hospitalizations per 100,000 population to 95.7 hospitalizations per 100,000 population. The rate in Region 4 decreased 5.6 percent, 51.9 hospitalizations per 100,000 population to 49.0 hospitalizations per 100,000 population. The rate in Region 8 decreased 11.8 percent, from 54.7 hospitalizations per 100,000 population to 61.1 hospitalizations per 100,000 population.

[28] Texas Health Care Information Collection (THCIC), Department of State Health Services

Figure 20 outlines the hospitalization for suicide attempt rates above the state rates by PHR for 2000-2018.

Figure 20. Hospitalization for Suicide Attempt Above the State Rate by Public Health Region (PHR), 2000-2018[29]

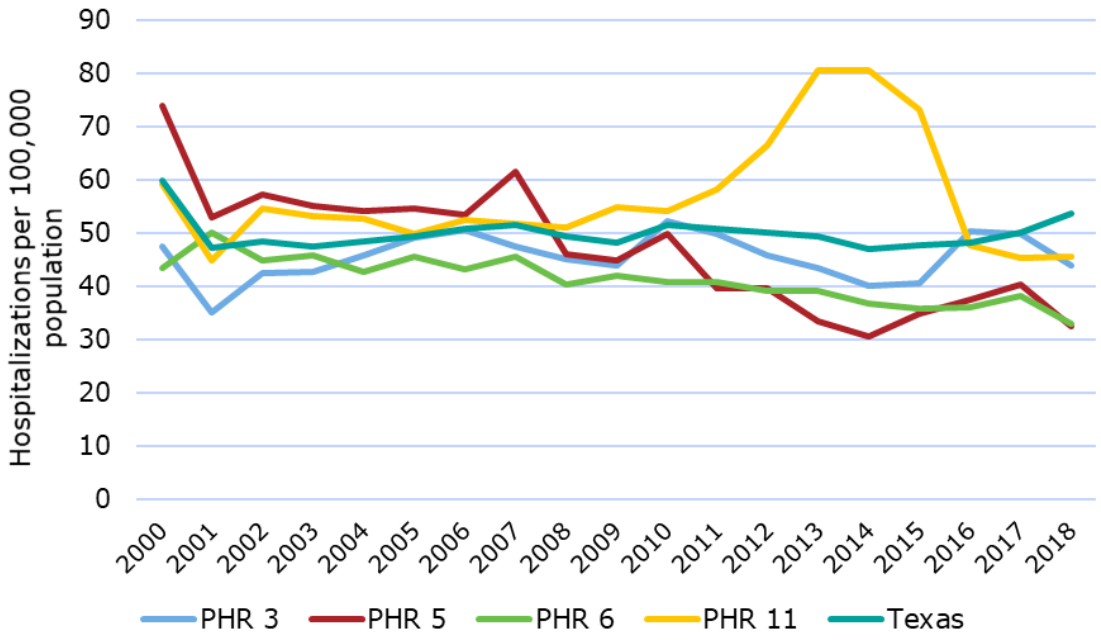


Public Health Regions 3, 5, 6, and 11 have hospitalization for suicide attempt rates similar to the state rate. The rate in region 3 increased 42.1 percent, from 35.1 hospitalizations per 100,000 population to 49.9 hospitalizations per 100,000 population. The rate for Region 5 decreased by 23.9 percent, from 53.0 hospitalizations per 100,000 population to 40.4 hospitalizations per 100,000 population. The rate for Region 6 also decreased by 23.9 percent, from 50.1 hospitalizations per 100,000 population to 38.2 hospitalizations per 100,000 population. The rate for Region 11, despite being very volatile, increased by only 0.8 percent, from 45.0 hospitalizations per 100,000 population to 45.3 hospitalizations per 100,000 population.

[29] Texas Health Care Information Collection (THCIC), Department of State Health Services

Figure 21 outlines the hospitalization for suicide attempt rates similar to the state rates by PHR from 2000-2018.

Figure 21. Hospitalization for Suicide Attempt Similar to the State Rate by Public Health Region (PHR), 2000-2018[30]



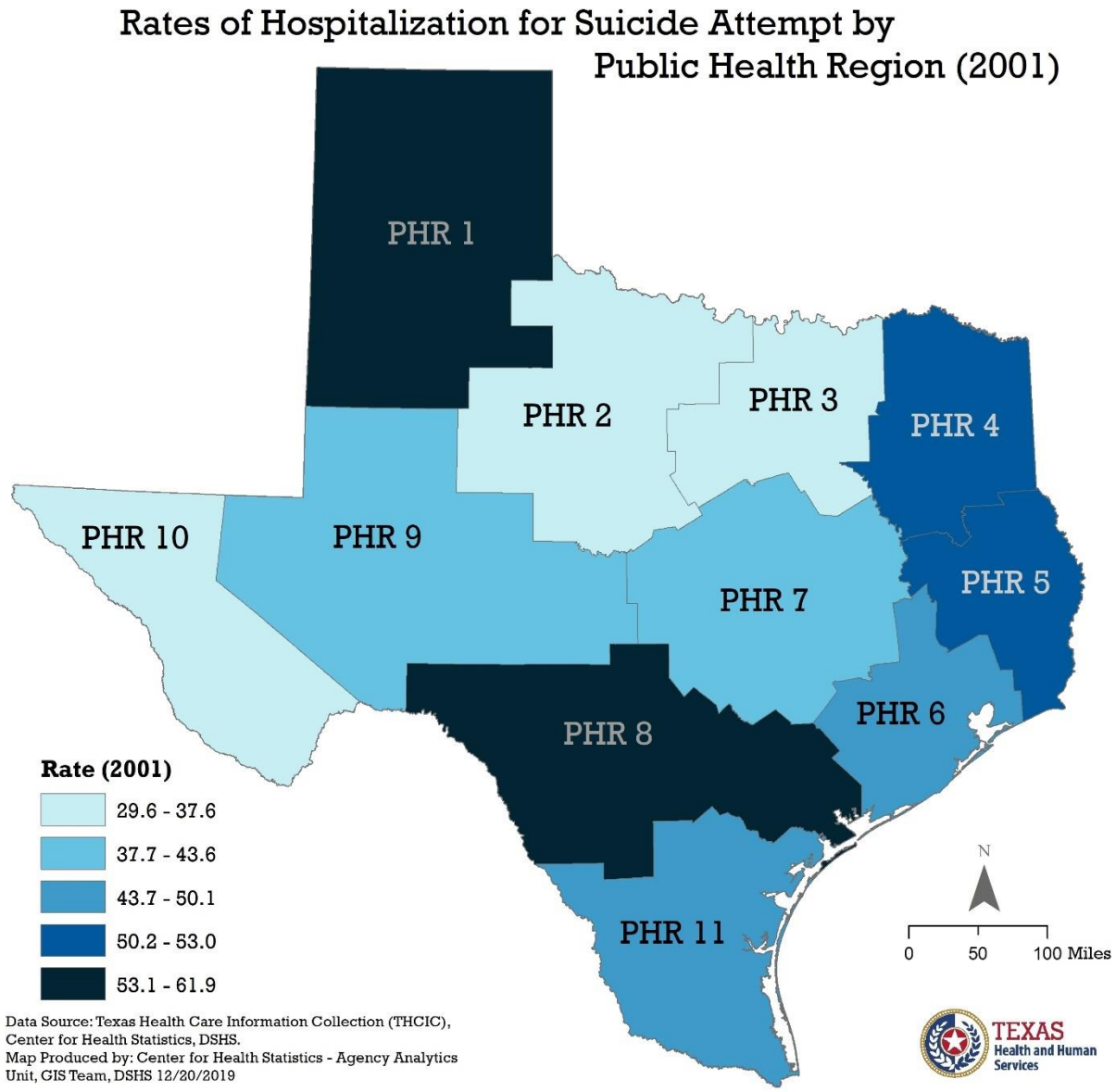
Snapshot of Public Health Regions

The next three pages provide maps of the suicide attempt hospitalization rate (per 100,000 population) for Public Health Regions providing a snapshot in time to compare the rates across regions. The first map shows 2001; the second shows 2010; and the third shows the most recent available data, 2018. Due to the anomalous spike in 2000, all examinations of Public Health Region data begin in 2001. In 2001, the highest rate of hospitalizations for suicide attempt was in Public Health Region 1 with 61.9 hospitalizations per 100,000 population. Public Health Regions 8 and 5 had similarly high rates of 54.7 hospitalizations per 100,000 population and 53.0 hospitalizations per 100,000 population, respectively. The lowest rate was in Public Health Region 10 with 29.6 hospitalizations per 100,000 population. Public Health Regions 3 and 2 also had low rates of 35.1 hospitalizations per 100,000 population and 37.6 hospitalizations per 100,000 population, respectively. The state rate was 47.2 hospitalizations per 100,000 population.

[30] Texas Health Care Information Collection (THCIC), Department of State Health Services

Figure 22 outlines the hospitalization rate for suicide attempts per 100,000 population by PHR in 2001.

Figure 22. Rates of Hospitalization for Suicide Attempt per 100,000 population by Public Health Region, Texas 2001[31]



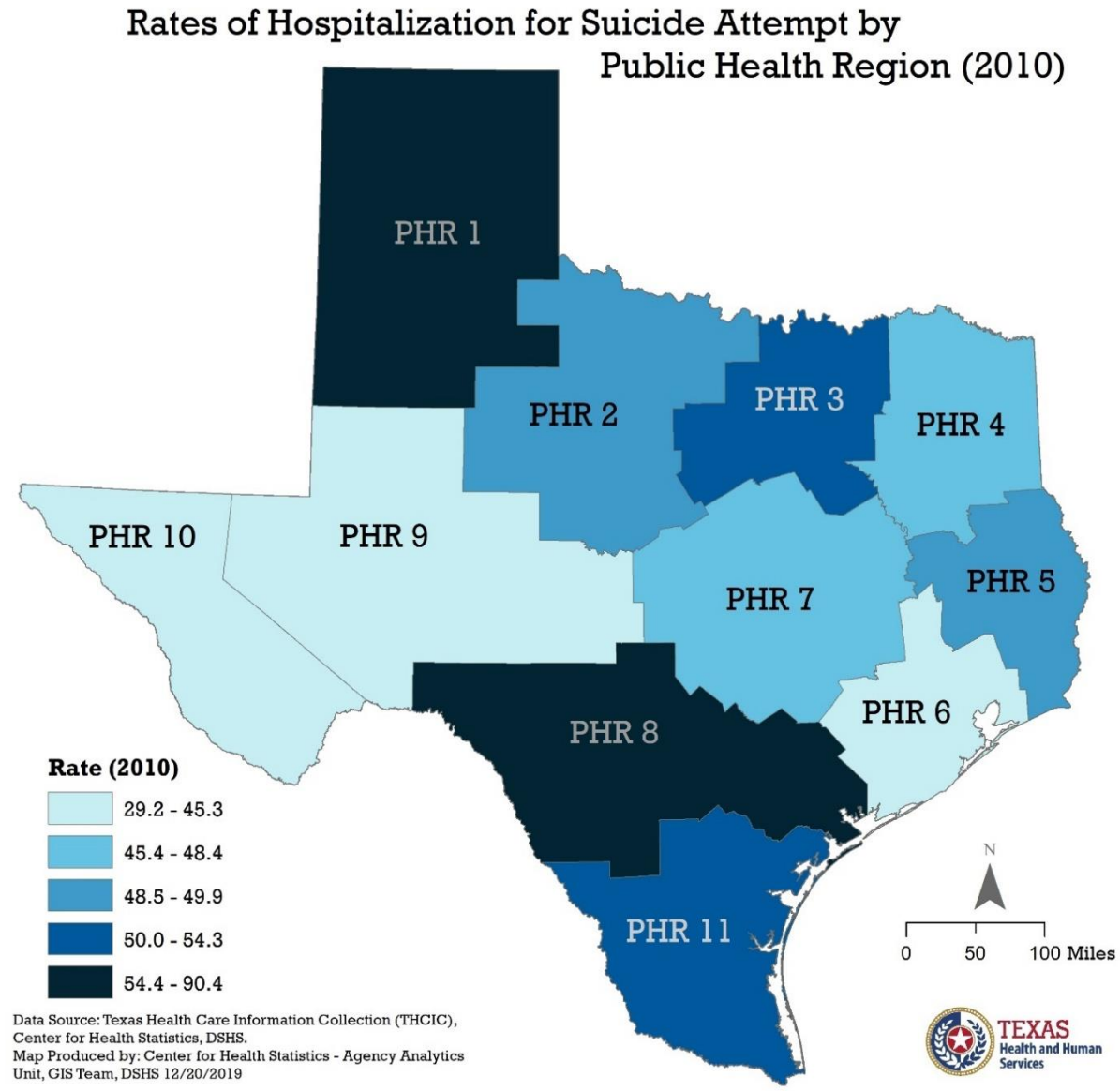
[31] Texas Health Care Information Collection (THCIC), Department of State Health Services

In 2010, the highest rate of suicide attempt hospitalization was in Public Health Region 1 with a rate of 90.4 hospitalizations per 100,000 population. Public Health Region 8 also had a high rate of 64.3 hospitalizations per 100,000 population.

The lowest rate was in Public Health Region 10 with a rate of 29.2 hospitalizations per 100,000 population. Public Health Regions 6, 9, and 7 also had lower rates with rates of 40.8 hospitalizations per 100,000 population, 45.3 hospitalizations per 100,000 population, and 45.8 hospitalizations per 100,000 population, respectively. The state rate was 51.5 hospitalizations per 100,000 population.

Figure 23 outlines the hospitalization rate for suicide attempts per 100,000 population by PHR in 2010.

Figure 23. Rates of Hospitalization for Suicide Attempt per 100,000 Population by Public Health Region, Texas 2010[32]



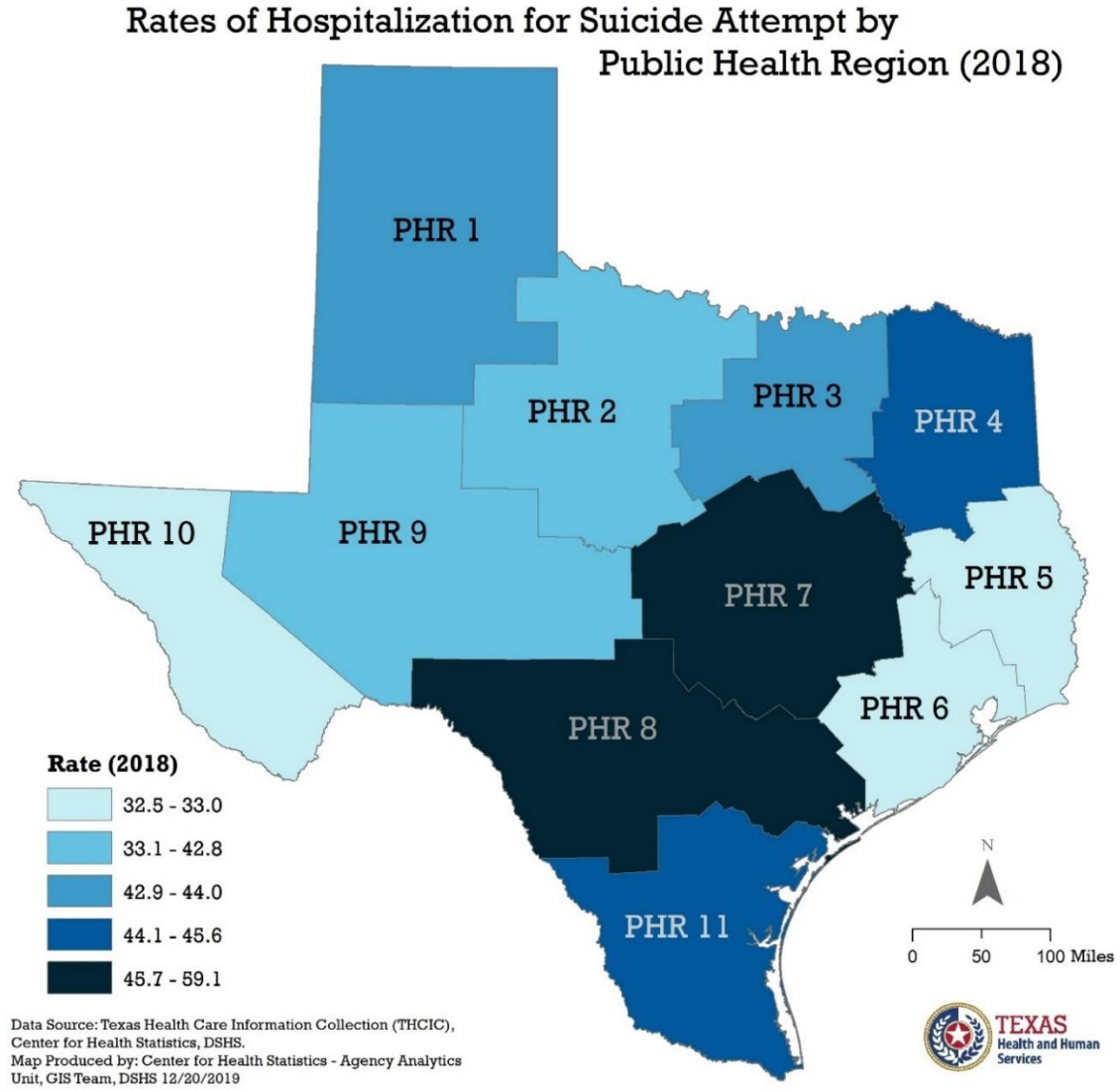
In 2018, the highest rates of suicide attempt hospitalizations were in Public Health Regions 8 and 7 with rates of hospitalization of 59.1 hospitalizations per 100,000 population and 58.3 hospitalizations per 100,000 population. The lowest rates were

[32] Texas Health Care Information Collection (THCIC), Department of State Health Services

in Public Health Regions 5, 10, and 6 with rates of 32.5 hospitalizations per 100,000 population, 32.5 hospitalizations per 100,000 population, and 33.0 hospitalizations per 100,000 population, respectively. The state rate was 53.8 hospitalizations per 100,000 population.

Figure 24 outlines the hospitalization rate for suicide attempts per 100,000 population by PHR in 2010.

Figure 24. Rates of Hospitalization for Suicide Attempt per 100,000 Population by Public Health Region, Texas 2018[33]



[33] Texas Health Care Information Collection (THCIC), Department of State Health Services

Race and Ethnicity[34]

The highest rates of inpatient hospitalization for suicide attempt are among individuals in the "other" race category, however this category saw the only decrease in hospitalization rate of 23.6 percent, from 79.2 hospitalizations per 100,000 population to 60.5 hospitalizations per 100,000 population. This relatively high rate may be an artifact due to a suppression rule that the Texas Health Care Information Collection (THCIC) follows to protect patient confidentiality. When a hospital has fewer than five cases in a race category during a given quarter, THCIC codes them as "other" to protect patient confidentiality and prevent patient identification. This could explain the relatively low rate among the black or African American population as well.

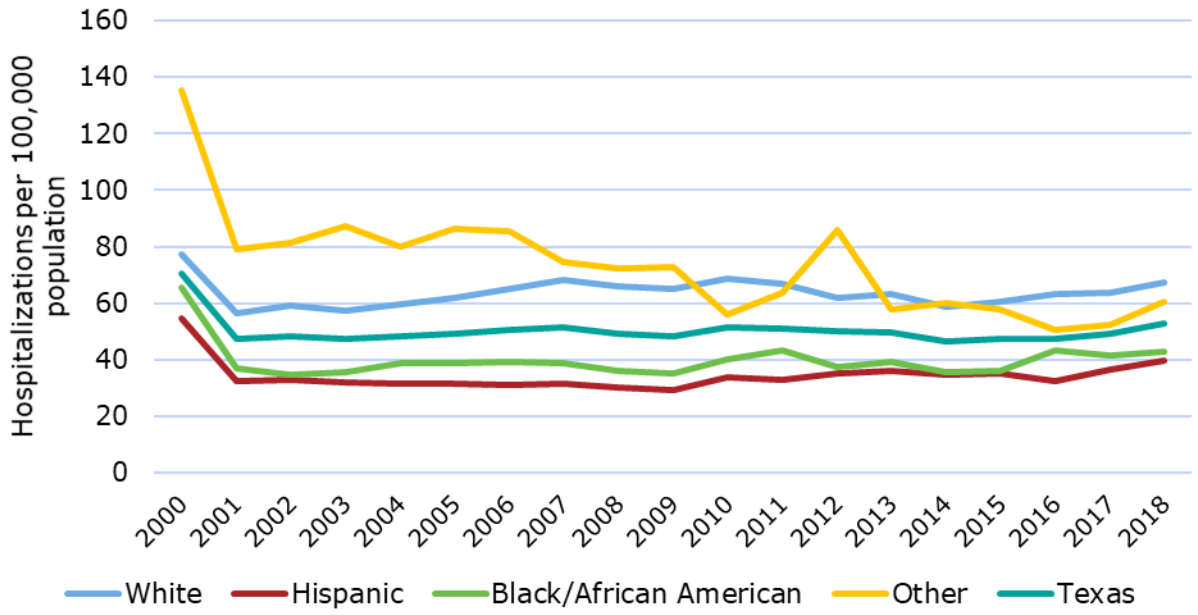
Whites have the next highest rate of inpatient hospitalization for suicide attempt with an 18.7 percent increase of 56.6 hospitalizations per 100,000 population to 67.2 hospitalizations per 100,000 population between 2001 and 2018.

Blacks or African Americans and Hispanics had relatively low rates of hospitalization, but both saw increases over the period from 2001 to 2018. The black or African American rate increased by 16.2 percent from 37.0 hospitalizations per 100,000 population to 43.0 hospitalizations per 100,000 population.
The Hispanic rate increased 22.9 percent from 32.3 hospitalizations per 100,000 population to 39.7 hospitalizations per 100,000 population.

[34] See Table 74 in Appendix A

Figure 25 outlines the hospitalization rates for suicide attempts by race and ethnicity for 2000-2018.

Figure 25. Hospitalization for Suicide Attempt by Race and Ethnicity, Texas 2000-2018[35]



Limitations of Hospitalization Data

The ICD-9 and ICD-10 codes used to identify hospitalizations for suicide attempt can also be used to code non-suicidal self-injury (NSSI), so there is a chance that the incidents coded in this analysis are not actually suicide attempts. The fact is that the injuries in this analysis were serious enough to require inpatient hospitalization and therefore were very serious injuries and most likely suicide and not NSSI.

The other major limitation of Hospital Discharge data is it being discharge-based and not individual-based. There is the possibility, although highly unlikely, that one group of individuals is repeatedly hospitalized for suicide attempt and accounting for the high number of hospital discharges as opposed to many people being hospitalized for suicide attempt.

[35] Texas Health Care Information Collection (THCIC), Department of State Health Services

Other limitations to hospitalization data are due to suppression of data elements to protect confidentiality of those hospitalized. Any case with an alcohol, drug, or Human Immunodeficiency Virus (HIV) diagnosis is automatically suppressed in several different ways. This includes suppressing sex and using broader age categorizations.

For this reason, it is not possible to provide data analysis based on the sex of the person admitted. Data by sex was suppressed in approximately half of hospital admissions for suicide. With only half of the discharges having known sex, we would have to assume that the unidentified discharges have a similar proportional breakdown to the known estimates to be unbiased. There is no way of knowing if these individuals had similar sex breakdowns to the individuals identified by sex in the dataset and thus if this suppression would bias the analysis.

The "other" race category also presents problems with suppression. When a hospital has fewer than five patients of a given race category in one quarter, those patients are coded as "other." It is assumed there may be African Americans in the "other" category. This data suppression while calculating a rate using the true population of "other" in Texas will create a mismatch of numerator and denominator and substantially overestimate the rate. In the future, it is recommended THCIC suppress these cases into missing instead of inaccurately populating the "other" category.

Sexual orientation and transgender status are not reported in hospital discharge documents. As a result, suicide attempt hospitalization data is not available for those two high risk groups. There are difficulties in calculating such rates because if the numbers were collected, the Texas demographer does not currently estimate population size for those groups. Therefore, there would not be a denominator for this population's suicide attempt hospitalizations.

Poison Control Center Data[36]

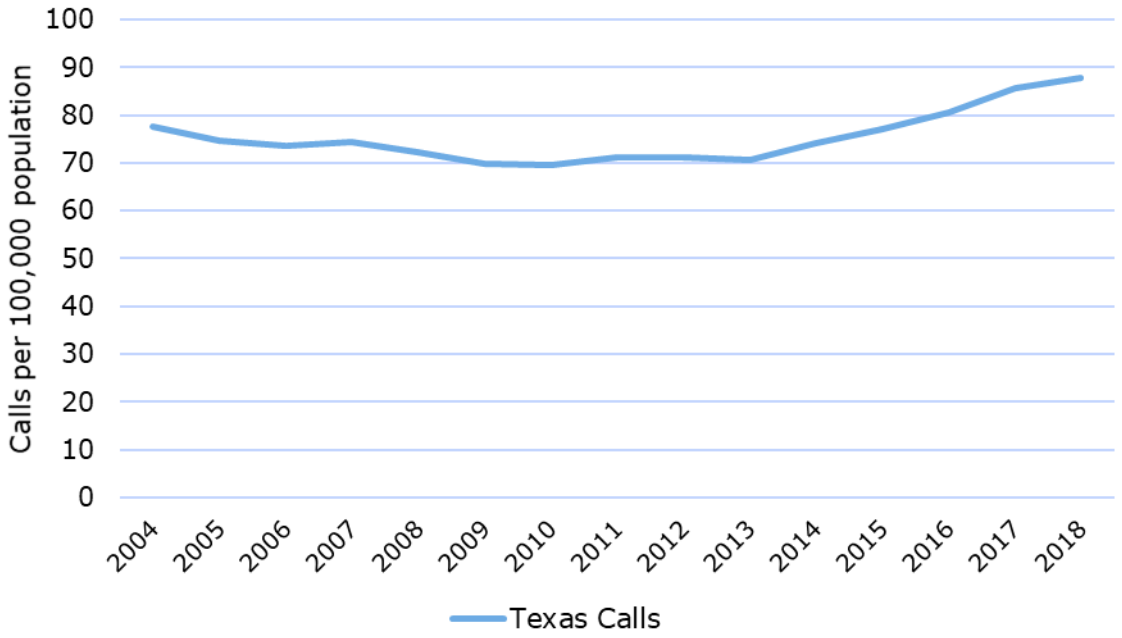
When a call is made to the Poison Control hotline, the caller identifies information about the subject of the call. The Poison Control Center receives calls from emergency departments, urgent care centers, doctors' offices, and the general public. Calls concerning self-inflicted poisonings are rising. The proportion of calls concerning adolescents is also increasing.

[36] See Table 75 in Appendix A

In the early 2000s, the percentage of calls of self-inflicted poisonings concerning adolescents 13-19 years old was about 23 percent; by 2015-2019, the percentage of calls for this reason concerning adolescents was 32 percent. The number of calls Poison Control receives concerning suspected suicide has been increasing in the time of available data, starting in 2004 when 17,391 calls were received until 2018 when 25,233 calls were received. This constituted a 13 percent increase in the call rate per 100,000 population, from 77.7 calls per 100,000 population to 87.9 calls per 100,000 population.

Figure 26 outlines suspected suicide calls received by Texas Poison Control Center for 2004-2018.

Figure 26. Texas Poison Control Center Suspected Suicide Calls, 2004-2018[37]



Age[38]

The highest rates for Poison Control calls concerning suspected suicide occurred with adolescents 13 to 19 years old. The rate was significantly lower among the 6 to 12-year-old population. The next highest rates were seen in the 20-29-year-old populations. Although the rates were very low in the youngest group, they saw the

[37] Texas Poison Control Network (TPCN), Department of State Health Services

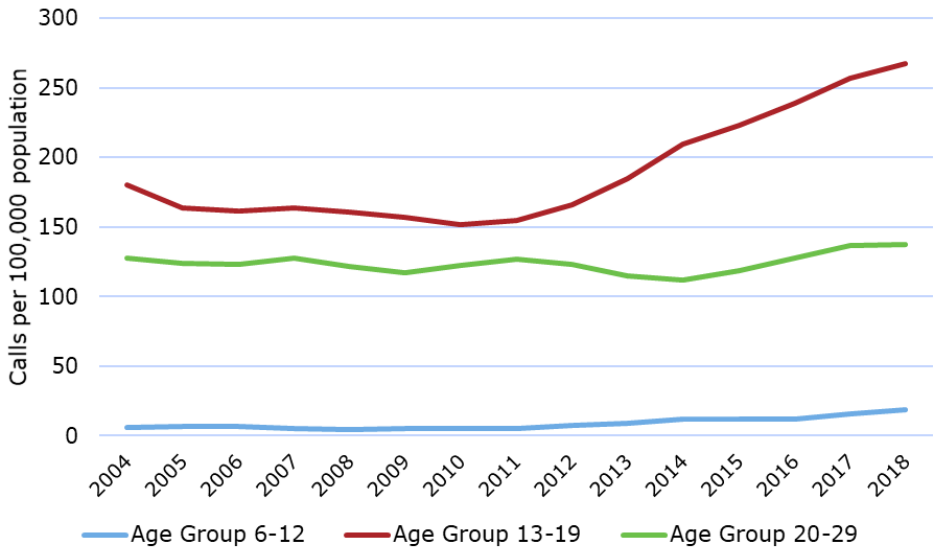
[38] See Table 76, Table 77, and Table 78 in Appendix A

largest increase, 226.5 percent, more than tripling the rate, from 5.7 calls per 100,000 populations to 18.7 calls per 100,000 population.

The adolescent age group of 13 to 19 years, also saw an increase of 48.4 percent, rising from 180.2 calls per 100,000 population to 267.5 calls per 100,000 population. The rate among individuals 20-29-years old remained relatively stable with just a 7.7 percent increase, from 127.6 calls per 100,000 population to 137.4 calls per 100,000 population.

Figure 27 outlines suspected suicide calls among youth and young adults received by Texas Poison Control Center for 2004-2018.

Figure 27. Texas Poison Control Center Suspected Suicide Calls Among Youth and Young Adults, 2004-2018[39]

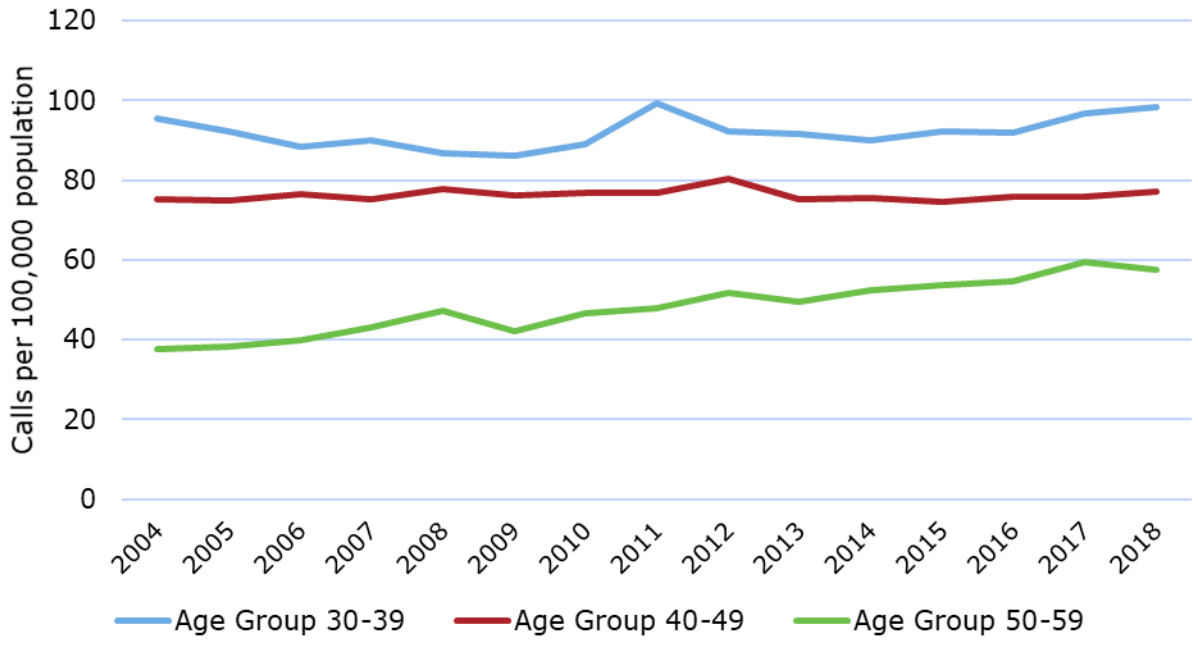


The rates of suspected suicide calls to the Poison Control Network continue to decline with age through the middle adult years. The rate also remained very steady among the 30-39-year-olds and the 40-49-year-olds with a 2.8 and 2.6 percent increase, respectively, over the 15-year period. The 30-39-year-old group rate went from 95.6 calls per 100,000 population to 98.2 calls per 100,000 population and the 40-49-year-old group rate went from 75.2 calls per 100,000 population to 77.2 calls per 100,000 population. However, the 50-59-year- old age group saw an increase of 52.5 percent, with rates rising from 37.8 calls per 100,000 population to 57.6 calls per 100,000 population.

[39] Texas Poison Control Network, Department of State Health Services

Figure 28 outlines suspected suicide calls among middle-aged adults received by Texas Poison Control Center for 2004-2018.

Figure 28. Texas Poison Control Center Suspected Suicide Calls Among Middle-Aged Adults, 2004-2018[40]

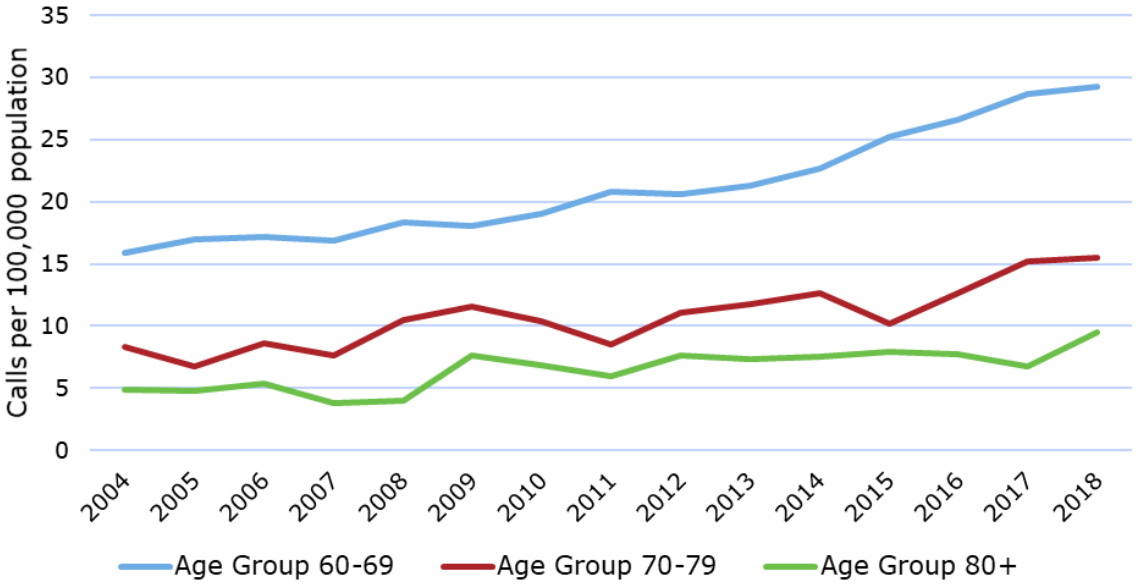


Older adults had the lowest Poison Control suspected suicide call rates; however, this age group experienced close to the highest increases in rates over the fifteen-year period. Calls for persons 80 and older increased 91.8 percent from a rate of 4.9 calls per 100,000 population to 9.5 calls per 100,000 population. Calls for persons 70-79 increased 85.8 percent from 8.3 calls per 100,000 population to 15.5 calls per 100,000 population. Calls for persons 60 to 69 increased 84.2 percent from 15.9 calls per 100,000 population to 29.2 calls per 100,000 population.

[40] Texas Poison Control Network, Department of State Health Services

Figure 29 outlines suspected suicide calls among older adults received by Texas Poison Control Center for 2004-2018.

Figure 29. Texas Poison Control Center Suspected Suicide Calls Among Older Adults, 2004-2018[41]



Limitations of Poison Control Data

The Poison Control Dataset is based on information given to the operator by the individual who phones the hotline. The data is therefore only as accurate as what is reported by the caller. Age is only reported in 10-year groupings for adults and in some cases reported as "unknown age adult" or "unknown age child." Cases identified as unknown age adult and unknown age child were left out of the analysis. Race and ethnicity are not reported because the caller may not be an accurate reporter of the subject's identity. The county where the call originates is reported, but since many calls come from treatment centers or the site of the incident, the calls may not provide accurate depictions of the county of residence. This data misinformation would cause a mismatch of numerator and denominator when calculating a population rate. Therefore, the analysis of county level data was left out of the Poison Control data analysis because of the question of accuracy compared with the Hospital Discharge or Mortality data sets.

[41] Texas Poison Control Network, Department of State Health Services

Emergency Department Outpatient Data[42]

DSHS currently collects inpatient and outpatient data from hospitals and ambulatory surgical centers. DSHS began collecting emergency department data from hospitals on January 1, 2015 per 25 Texas Administrative Code (TAC), Sections 421.71-421.78, and in conjunction with the collection of inpatient and outpatient data.[43] The first year data was available is from 2016.

In the past three years, there have been over 18,000 emergency room visits each year for suicide attempt or non-suicidal self-injury where the patient has been treated and not admitted to the hospital. While these incidents only account for a small portion of emergency room visits each year, the number of visits in emergency department for suicide attempt is more than five times the number of suicide deaths each year in Texas. Both the number of emergency room visits and the rate per 100,000 population have risen over these three years.

Public Health Region[44]

The rate of outpatient emergency room hospitalizations is not evenly dispersed across the state. Region 2 had the highest rates, followed by Region 4 and Region 7. All regions had rates increasing during the three-year period.

The largest increase was in Region 4 with a 43.2 percent increase from 71.2 hospitalizations per 100,000 population to 102.0 hospitalizations per 100,000 population. Region 6 had the next largest increase of 30.1 percent from 48.0 hospitalizations per 100,000 population to 62.4 hospitalizations per 100,000 population. Region 10 experienced a 19.4 percent increase rising from 55.7 hospitalizations per 100,000 population to 66.5 hospitalizations per 100,000 population. Regions 9 and 11 both experienced 18.6 percent increases. Region 9 rose from 62.7 hospitalizations per 100,000 population to 74.3 hospitalizations per 100,000 population. Region 11 rose from 52.3 hospitalizations per 100,000 population to 62.0 hospitalizations per 100,000 population. Regions 7 and 8 experienced an 18.5 and an 18.1 percent increase with rates increasing from 72.9 hospitalizations per 100,000 population to 86.4 hospitalizations per 100,000

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[42] See Table 79 in Appendix A

[43] Texas Health Care Information Collection (THCIC), Department of State Health Services

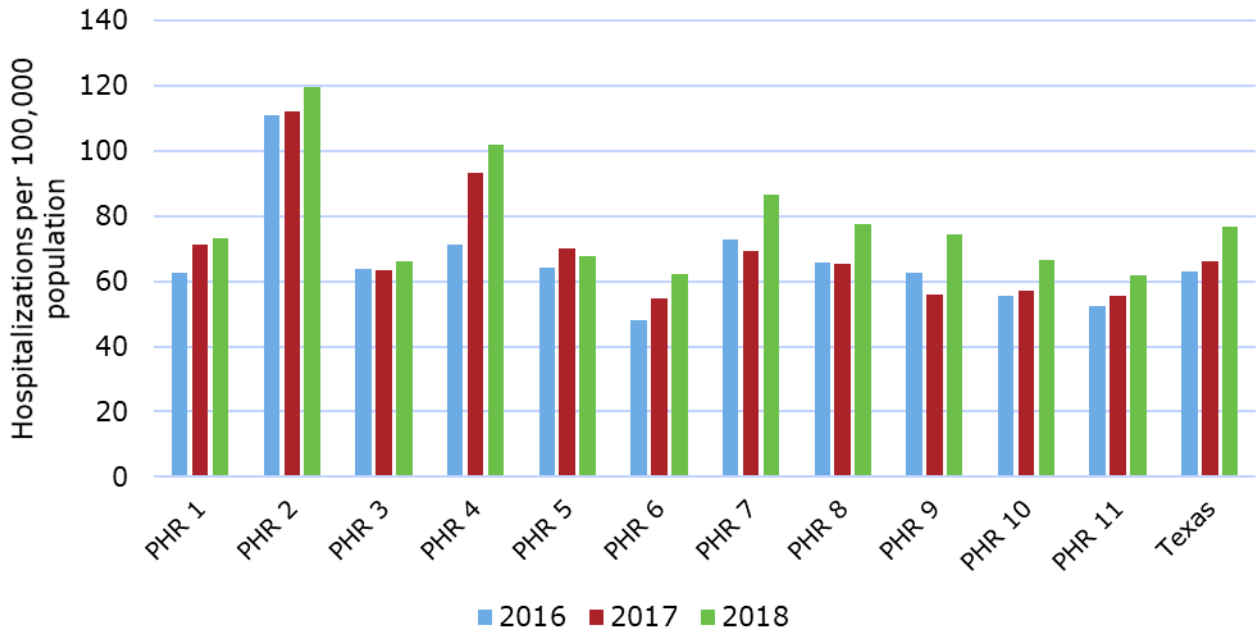
[44] See Table 80 in Appendix A

population and from 65.6 hospitalizations per 100,000 population to 77.4 hospitalizations per 100,000 population, respectively.

Region 1 experienced a 17.4 percent increase with rates rising from 62.5 hospitalizations per 100,000 population to 73.3 hospitalizations per 100,000 population. The smallest increases were in Regions 2, 3, and 5. Region 2 had an 8 percent increase from 110.8 hospitalizations per 100,000 population to 119.6 hospitalizations per 100,000 population. Region 5 had a 5.5 percent increase from 64.2 hospitalizations per 100,000 population to 67.8 hospitalizations per 100,000 population. And Region 3 had a 3.9 percent increase from 64.2 hospitalizations per 100,000 population to 67.8 hospitalizations per 100,000 population.

Figure 30 outlines emergency department outpatient hospitalizations for suicide attempt by PHR for 2016-2018.

Figure 30. Emergency Department Outpatient Hospitalizations for Suicide Attempt by Public Health Region (PHR), 2016-2018[45]



[45] Texas Health Care Information Collection (THCIC), Department of State Health Services

Race and Ethnicity[46]

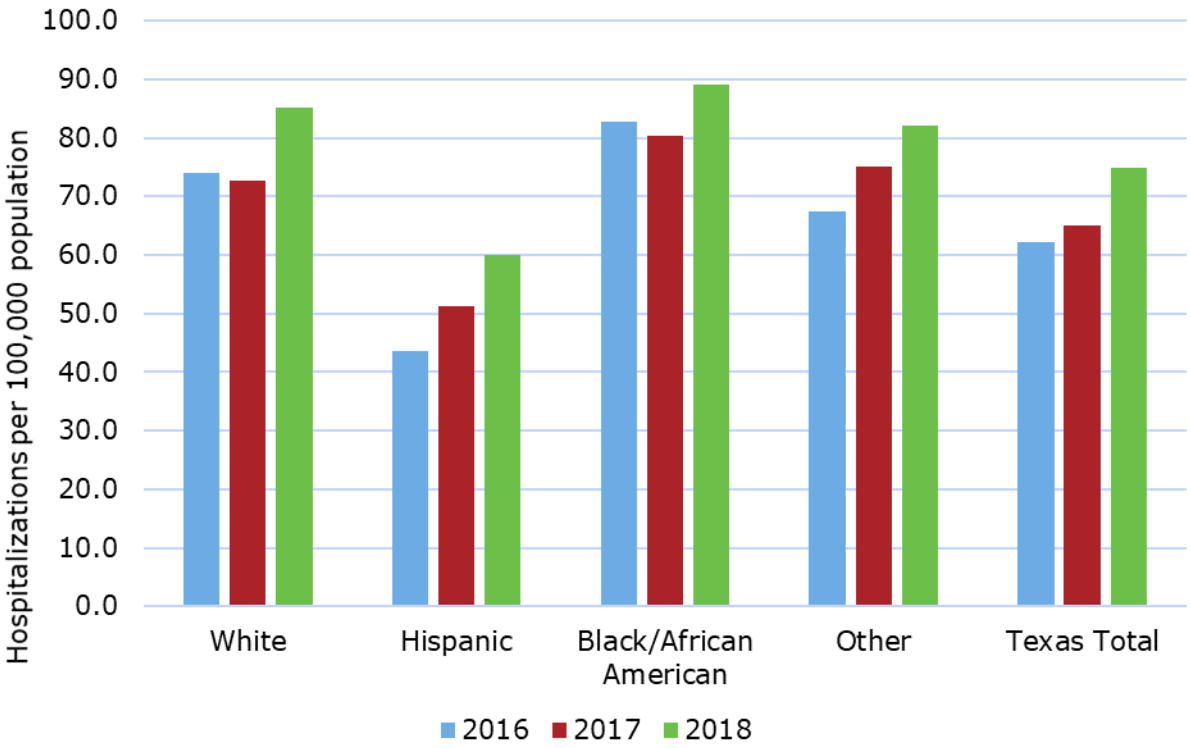
The black or African-American population had the highest rates of outpatient emergency department hospitalizations among race and ethnicity groupings, followed by the white and other groupings. Hispanics had the lowest rates; however, all groups saw rates increase over the three-year period.

The largest rate increase was in the Hispanic grouping with a 37.9 percent increase from 43.5 hospitalizations per 100,000 population to 60.0 hospitalizations per 100,000 population. The other grouping had the next largest increase with 21.9 percent, rising from 67.4 hospitalizations per 100,000 population to 82.2 hospitalizations per 100,000 population. Whites had a 14.9 percent increase from 74.0 hospitalizations per 100,000 population to 85.0 hospitalizations per 100,000 population. And black or African Americans had the smallest rate increase of 7.5 percent from 82.8 hospitalizations per 100,000 population to 89.0 hospitalizations per 100,000 population.

[46] See Table 81 in Appendix A

Figure 28 outlines emergency department outpatient hospitalizations for suicide attempt by race and ethnicity from 2016-2018.

Figure 31. Emergency Department Outpatient Hospitalizations for Suicide Attempt by Race and Ethnicity, Texas 2016-2018[47]



Limitations of Emergency Department Outpatient Data

The Emergency Department Outpatient dataset only includes emergency departments that are physically connected to hospitals. Due to this limitation, this analysis does not include visits to freestanding emergency rooms.
Like the Hospital Discharge Dataset, the Emergency Room Outpatient Public Use Data File is suppressed in multiple ways to protect the confidentiality of patients, beyond excluding all personal health identifiers. If the diagnosis codes include drug, alcohol, or HIV, then the sex of the patient is suppressed. Since about half of the suicide admissions data had sex suppressed, it was not possible to include analysis based on sex in this report. In these cases, the age is also suppressed into larger groupings which limits and seriously complicates the analysis on age; therefore, age was not included in this report.

[47] Texas Health Care Information Collection (THCIC), Department of State Health Services

Behavioral Risk Factor Surveillance System

The Texas Behavioral Risk Factor Surveillance System (BRFSS) is a random digit telephone survey of non-institutionalized adults throughout the state of Texas. It is part of a system of surveys coordinated by the CDC beginning in 1984, that are conducted in all fifty states, the District of Columbia, and three U.S. territories. Nationwide, BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

The Texas BRFSS interviews about 10,000 people each year. Surveys are conducted in English and Spanish and last about 25-30 minutes. The results are weighted on 14 different variables, to match the true population of the state of Texas. Therefore, the results are representative of all adults living in Texas, not just those who answered the survey. More than half of respondents receive their call on a cell phone. The survey was answered by 60 percent cell phone and 40 percent landline in 2016 and 2017 and increased to 70 percent cell phone and 30 percent landline in 2018.

Four questions concerning suicide were added to the Texas BRFSS in 2016, 2017, and 2018. The questions ask 1) if the respondent seriously considered attempting suicide in the past 12 months, 2) attempted suicide in the past 12 months, 3) how many times (if they said yes to the previous question), and 4) if any suicide attempt in the past 12 months required medical attention (again, only asked if they answered yes to the second question).

Suicide Attempt

The results from three years of BRFSS data are insufficient to analyze suicide attempt in adults in Texas. The questions regarding suicide were specifically placed at the end of the survey due to being sensitive in nature.

As a result, not all survey respondents answered those questions as respondents often drop out of the survey before its completion due to its length. Even with the extensive sample of 10,000 per year, a very small number of individuals responded that they had attempted suicide in the past 12 months. The overall prevalence of attempting suicide in the past 12 months was 0.6 percent.

Given the rarity of the event, rates by demographics or regions could not be calculated with any accuracy. For example, there was a calculated rate for whites, but the rates for blacks or African Americans, Hispanics, and others were all unstable due to the low prevalence rates. The BRFSS team estimates it will take at

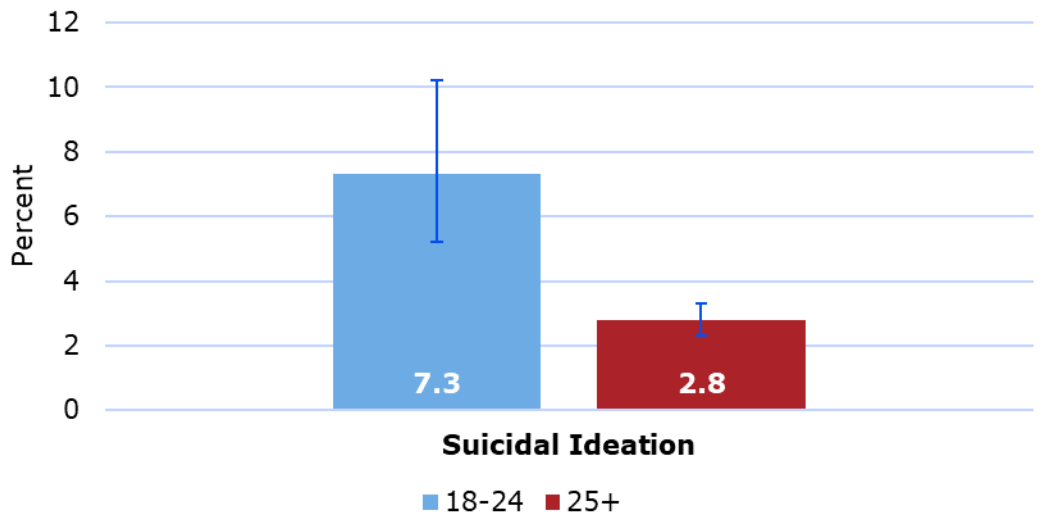
least five years of data to make stable estimates based on demographics and this data collection is still underway.

Suicidal Ideation[48]

Suicidal ideation was slightly more common and thus easier to analyze. The highest rates of suicidal ideation were in young adults, 18-24 years old. Males and females had essentially the same rates and rates across race and ethnicity (where they could be calculated) were similar.

Figure 33 outlines suicidal ideation in the past 12 months by young adults and adults for 2016-2018,

Figure 33. Suicidal Ideation in the Past 12 Months by Young Adult and Adult, Texas BRFSS, 2016-2018[49]



[48] See Table 82 in Appendix A

[49] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Figure 34 outlines suicidal ideation in the past 12 months by sex for 2016-2018.

Figure 34. Suicidal Ideation in the Past 12 Months by Sex, Texas BRFSS, 2016-2018[33]

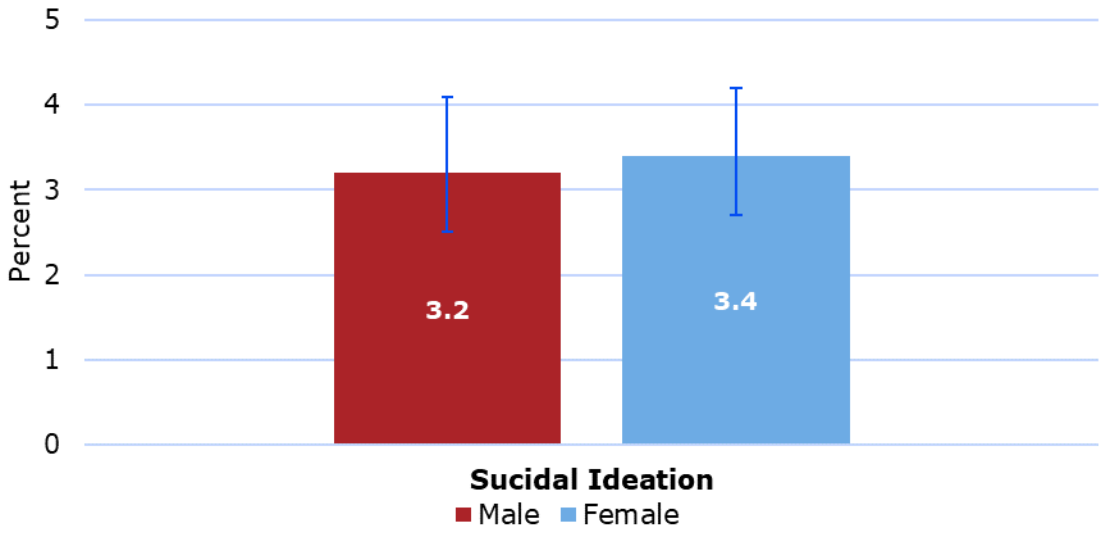
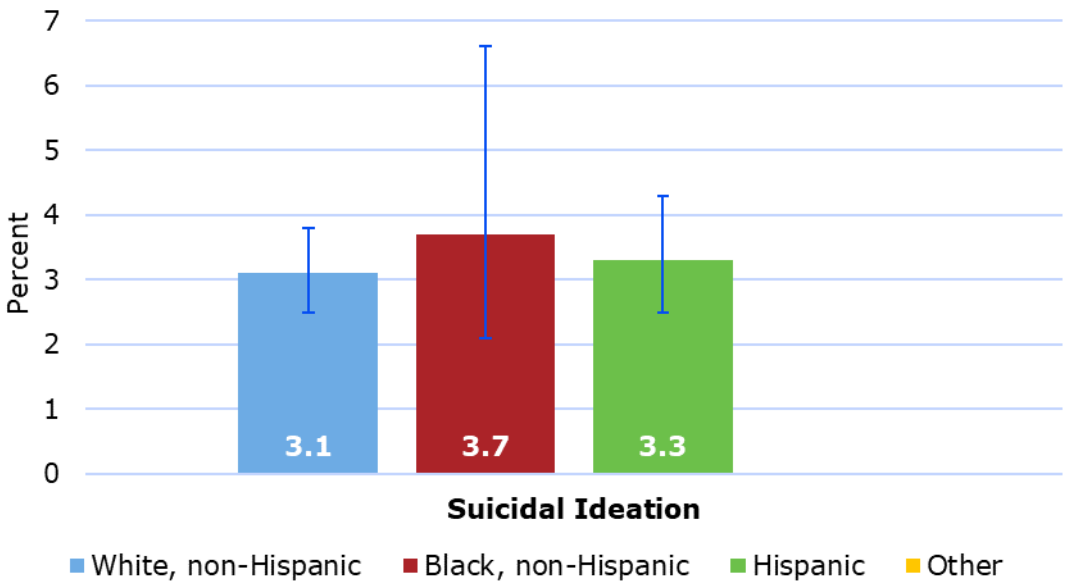


Figure 35 outlines suicidal ideation in the past 12 months by race and ethnicity for 2016-2018.

Figure 35. Suicidal Ideation in the Past 12 Months by Race and Ethnicity, Texas BRFSS, 2016-2018[50]

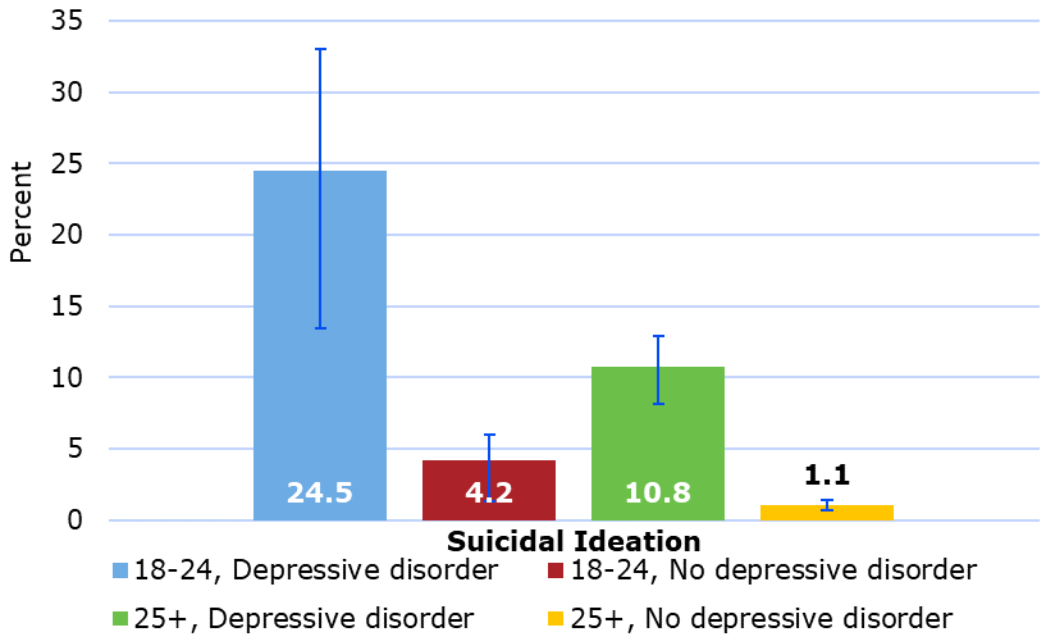


Three factors were found to increase the risk of having suicidal ideation in the past 12 months for both the 18-24-year-old age group, and the over 25-year-old age group. The first factor was the individual having been diagnosed with a depressive disorder. Young adults were about six times as likely to have suicidal ideation if they had been diagnosed with a depressive disorder and adults were about ten times as likely.[xii]

[50] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Figure 36 outlines suicidal ideation in the past 12 months by age group and depressive disorder status for 2016-2018.

Figure 36. Suicidal Ideation in the Past 12 Months by Age Group and Depressive Disorder Status, Texas BRFSS 2016-2018[51]

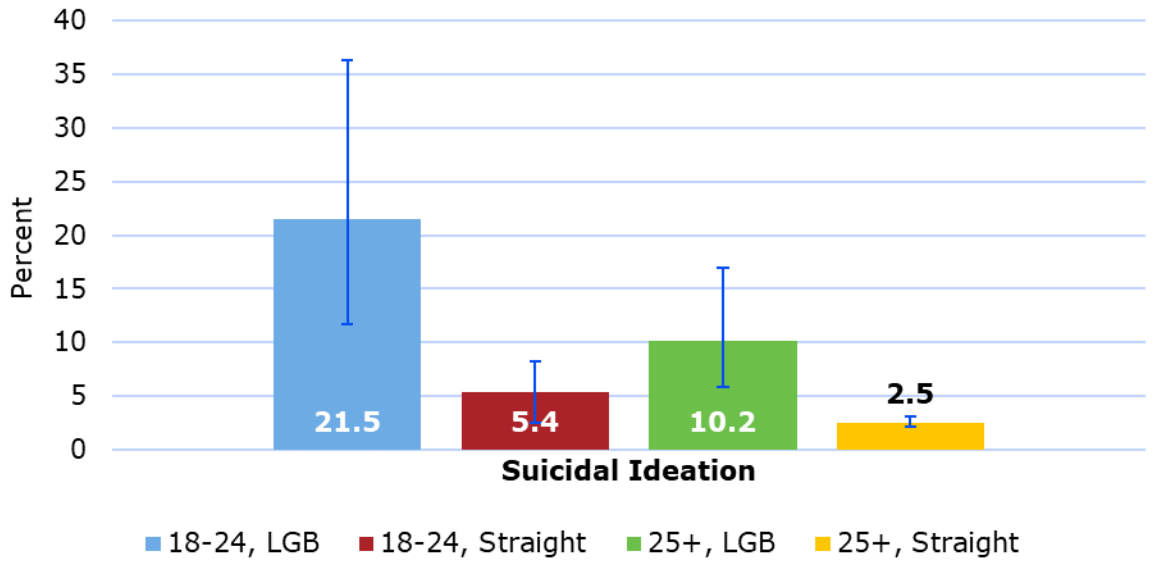


The second factor found to increase the risk of having suicidal ideation in the past 12 months for both the 18-24-year-old age group, and the over 25-year-old age group was sexual orientation. Individuals who identify as gay, lesbian, or bisexual were found to have higher rates of suicidal ideation in the past 12 months compared to those who identified as straight or heterosexual. Young adults and adults both were about five times as likely to have suicidal ideation if they also identified as gay, lesbian, or bisexual. The rates for those who identify as transgender were too unstable to analyze due to rarity.[xiii]

[51] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Figure 37 outlines suicidal ideation in the past 12 months by age group and sexual orientation for 2016-2018.

Figure 37. Suicidal Ideation in the Past 12 Months by Age Group and Sexual Orientation, Texas BRFSS 2016-2018[52]



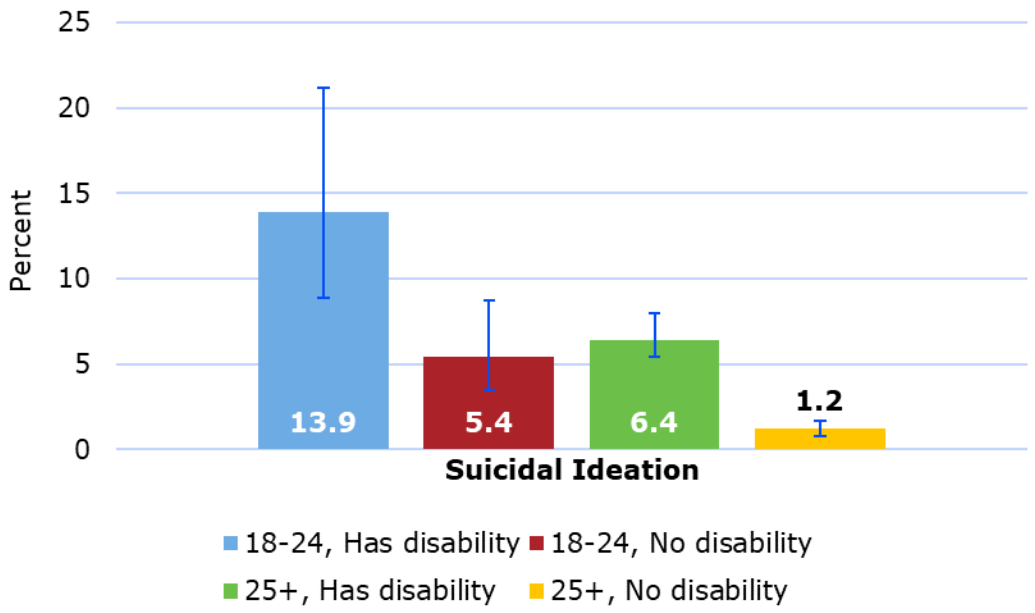
Disability status in the BRFSS is based on a series of six questions asking about the respondents' ability to do certain activities. The questions ask if the respondent: is deaf or has serious difficulty hearing; has difficulty seeing even with corrective lenses; has serious difficulty concentrating, remembering or making decisions due to a physical, mental, or emotional condition; has serious difficulty walking or climbing stairs; has difficulty dressing or bathing; or has difficulty completing errands alone such as shopping or visiting a doctor's office due to a physical, mental, or emotional condition. If the respondent answers yes to any of these questions, they are considered to have a disability for the purposes of analysis.

Among the 18-24-year-old age group, individuals who responded yes to at least one of these questions were two and a half times as likely to have also had suicidal ideation. In the 25 years and older age group, these individuals were more than five times as likely to have suicidal ideation.[xiv]

[52] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Figure 38 outlines suicidal ideation in the past 12 months by age group and disability status for 2016-2018.

Figure 38. Suicidal Ideation in the Past 12 Months by Age Group and Disability Status, Texas BRFSS, 2016-2018[53]



Limitations of Behavioral Risk Factor Surveillance System (BRFSS)

The relative rarity of suicide attempt among most adults makes it difficult to estimate rates even in a large-scale telephone survey like the BRFSS. There is also some consideration that individuals who have attempted suicide may have more difficulty reporting their suicidal thoughts, or ideation, on a telephone interview with a live person than on an anonymous written survey instrument. As there is distinctively more suicidal ideation among the younger population, it may be appropriate to posit that there are also more suicide attempts among the younger population. This is problematic because the survey does very well receiving responses from older adults, but has much more difficulty obtaining responses from young adults. While the weighting of the survey data fixes that issue for most areas, it would not help with the low number of respondents who admit to attempting suicide in the past 12 months.

[53] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Youth Risk Behavior Survey

The Texas Youth Risk Behavior Survey (YRBS) is a biennial survey of students in randomly selected classrooms in randomly selected high schools conducted in odd-numbered years. It monitors health-related behaviors that contribute to the leading causes of morbidity and mortality in adolescence and adulthood.

The YRBS asks five questions concerning suicide. All questions ask about the time frame of the past 12 months. The first question is a proxy for depression, asking if the student has been sad or depressed for at least two weeks such that they discontinued their usual activities. The next two questions ask about suicidal ideation and if the student had made a plan to attempt suicide. The last questions ask if the student has attempted suicide, if so, how many times, and if medical attention was required for any of the attempts.

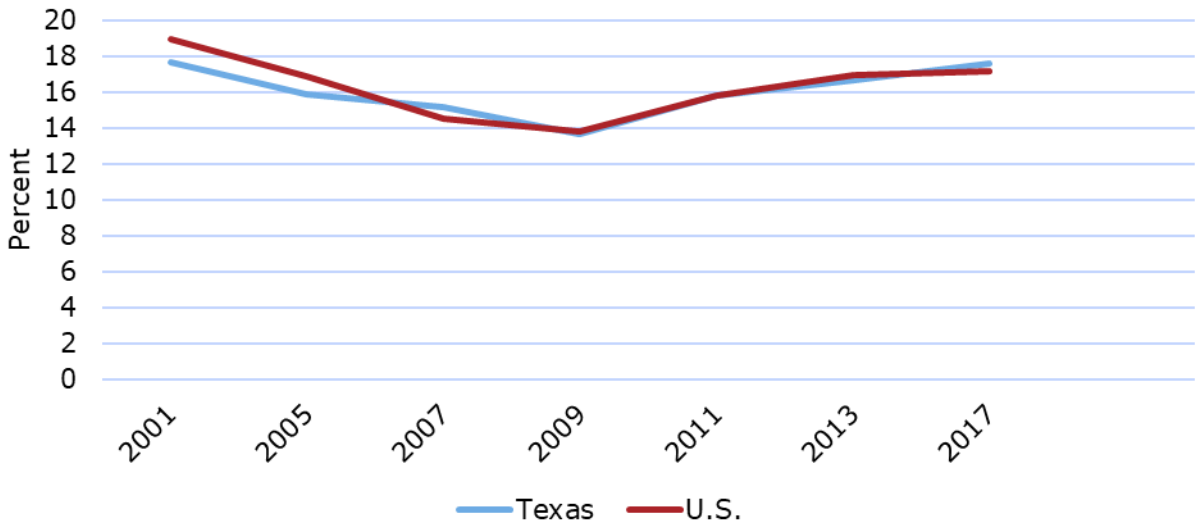
Suicidal Ideation[54]

The rate of suicidal ideation, or seriously considering attempting suicide, among Texas high school students is similar to that of students nationwide. It has remained the same, statistically, over the past 18 years.

[54] See Table 86 in Appendix A

Figure 39 outlines the percentage of Texas and U.S. high school students who seriously considered attempting suicide in the past 12 months for 2001-2017.

Figure 39. High School Students Who Seriously Considered Attempting Suicide in the Past 12 Months, Texas and the U.S., YRBS 2001-2017[55]



Sex[56]

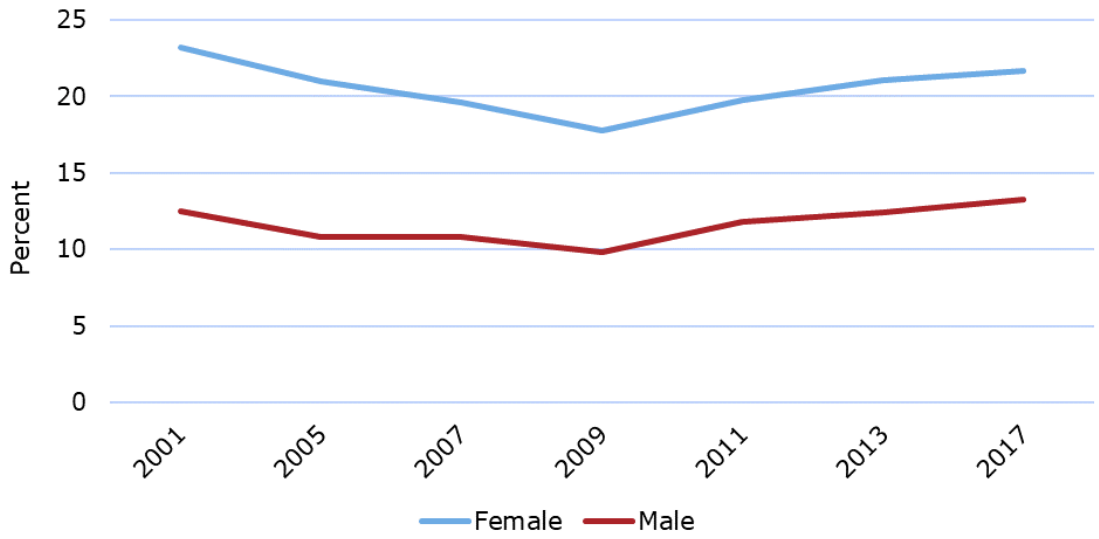
Females are nearly twice as likely as males to seriously consider attempting suicide. The net change in rates from 2001-2017 is the same, with the rate for females decreasing by 6 percent, from 23.2 percent to 21.7 percent and the rate for males increasing by 6 percent, from 12.5 percent to 13.3 percent.

[55] Centers for Disease Control and Prevention, 2001-2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs

[56] See Table 87 in Appendix A

Figure 40 outlines the percentage of Texas high school students who seriously considered attempting suicide in the past 12 months by sex for 2001-2017.

Figure 40. Texas High School Students Who Seriously Considered Attempting Suicide in the Past 12 Months by Sex, Texas YRBS, 2001-2017[57]



Race and Ethnicity[58]

Suicidal ideation rates by race and ethnicity in the YRBS should be cautiously considered since the sample size can be small for the black or African American and other categories causing the differences to rarely be statistically significant. The rate for other is high, but not statistically significant. Over the 18 years there is a 21 percent decrease in this group's rate, from 24.2 percent to 19.1 percent.

Hispanic rates are also higher than white rates during some years, but not others. There is a net decrease of 17 percent in the rate of suicidal ideation among Hispanic students, from 19.9 percent to 16.6 percent.

The largest increase was in white students where the rate increased 18 percent from 16.8 percent to 19.8 percent. There was also an increase in the rates among black or African American students of 14 percent, from 13.9 percent to 15.9 percent.

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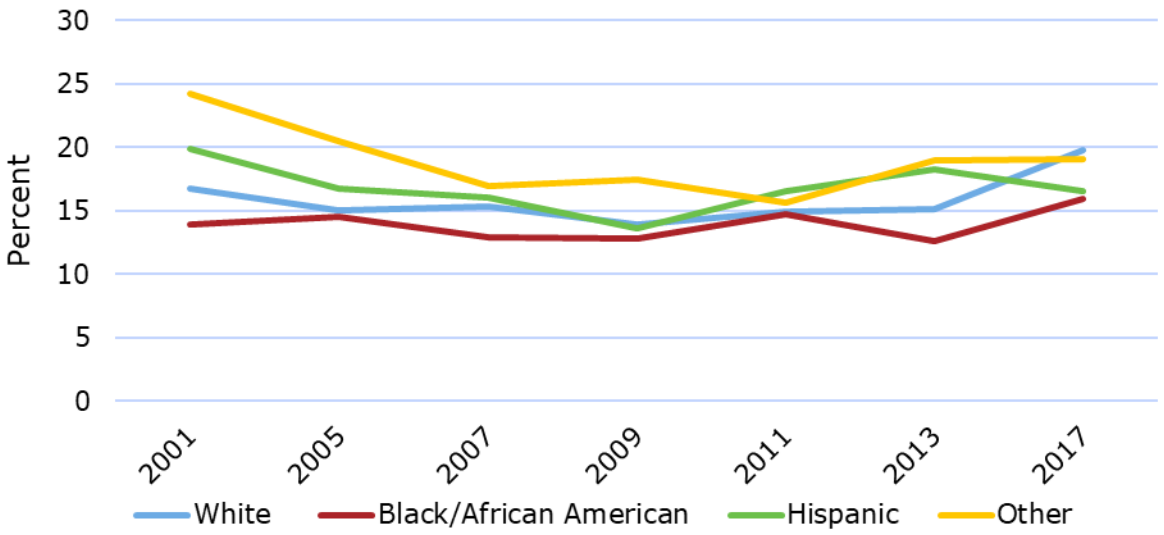
[57] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

[58] See Table 88 in Appendix A

Figure 41 outlines the percentage of Texas high school students who seriously considered attempting suicide in the past 12 months by race and ethnicity for 2001-2017.

Figure 41. Texas High School Students Who Seriously Considered Attempting Suicide in the Past 12 Months by Race and Ethnicity, Texas YRBS 2001-2017[59]



Suicide Attempt[60]

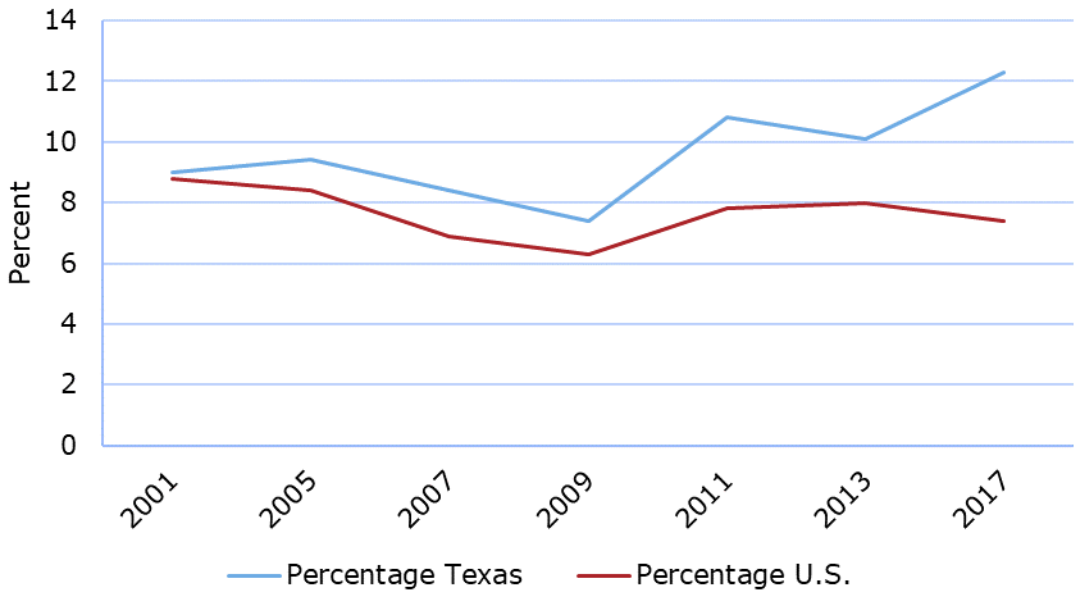
Texas' suicide attempt rate for high school students is higher than the national rate by 66 percent. The rate has increased 37 percent since Texas began measuring the rate in 2001, while the U.S. rate has decreased in the same time frame.

[59] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

[60] See Table 89 in Appendix A

Figure 42 outlines the percentage of Texas and U.S. high school students who attempted suicide in the past 12 months for 2001-2017.

Figure 42. Texas High School Students Who Attempted Suicide in the Past 12 Months in Texas and the U.S., YRBS, 2001-2017[61]



Sex[62]

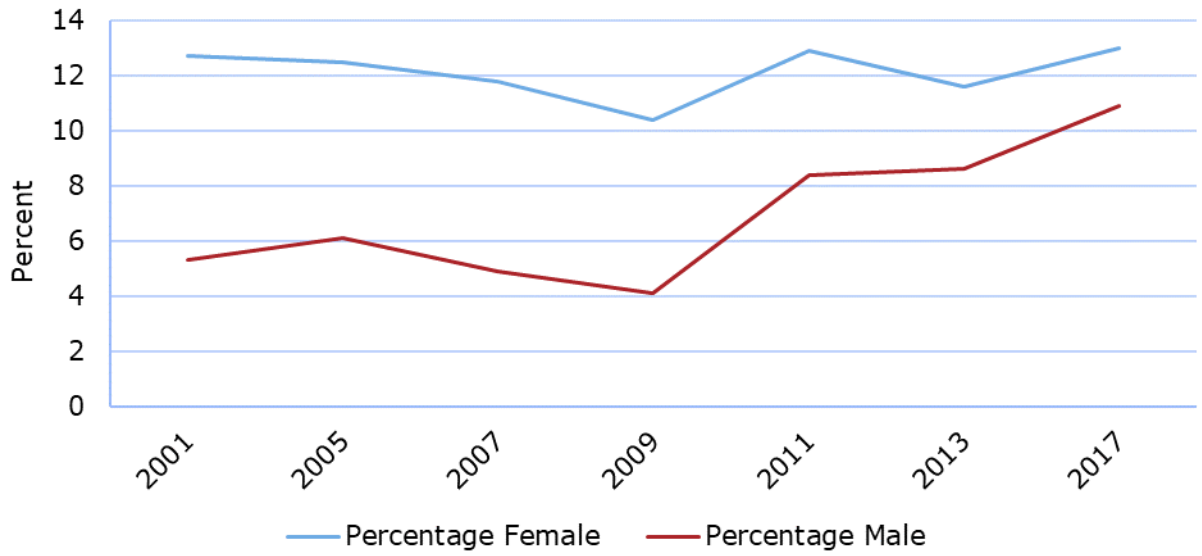
The suicide attempt rate for high school students differs between males and females, with females having the higher rate of suicide attempt. The rate for females has stayed relatively stable, however, the rate for males has more than doubled, from 5.3 percent to 10.9 percent.

[61] Centers for Disease Control and Prevention, 2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs

[62] See Table 90 in Appendix A

Figure 43 outlines the percentage of Texas high school students who attempted suicide in the past 12 months by sex for 2001-2017.

Figure 42. Texas High School Students Who Have Attempted Suicide in the Past 12 Months by Sex, Texas YRBS, 2001-2017[63]



Race and Ethnicity[64]

Suicide attempt rates for high school students by race and ethnicity in the YRBS should be cautiously considered since the sample size can be small for the black or African American and other categories causing the differences to rarely be statistically significant. Taking that into account, the rates of attempted suicide among white students appears to be the lowest of the race and ethnicity groupings; however, this rate still increased between 2001 and 2017 by 69 percent, from 6.7 percent to 11.3 percent. The black or African American grouping saw the greatest increase, more than doubling with a 123 percent increase, from 8.4 percent to 18.7 percent. At least half of this increase occurred in 2017 alone, coinciding with an increase seen nationally in suicide attempts among black or African American students. The rate among Hispanic students was relatively stable and decreased 6 percent, from 12.1 percent to 11.4 percent. The rate among other students was highly volatile but decreased overall by 39 percent, from 13.5 percent to 8.2 percent.

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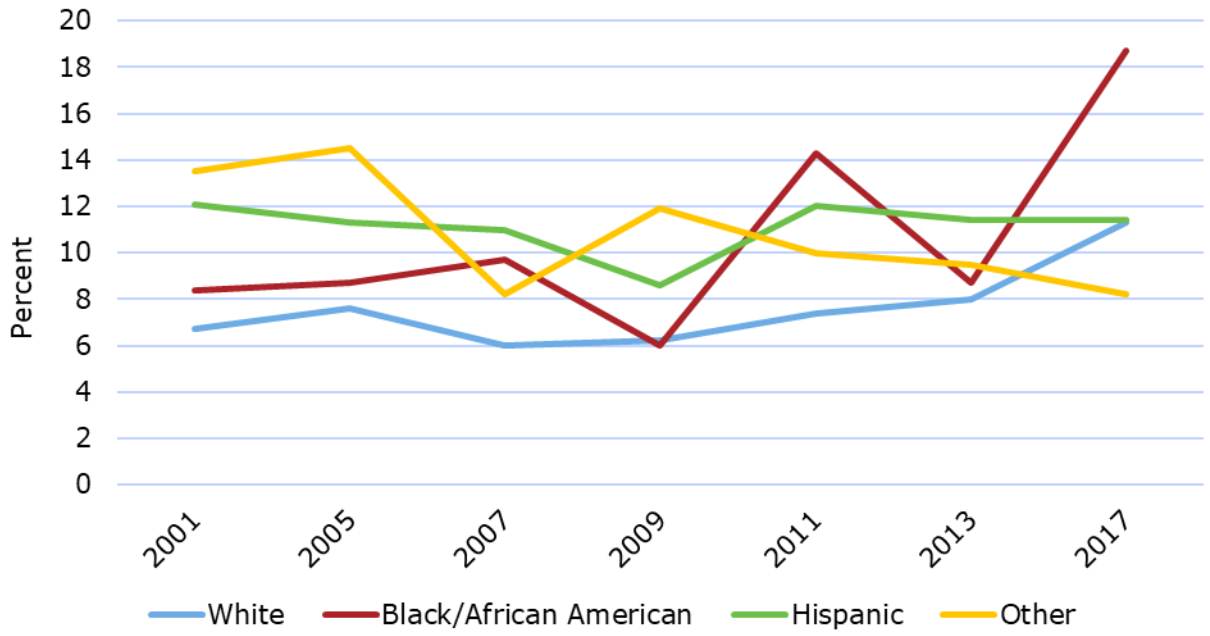
[63] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

[64] See Table 91 in Appendix A

Figure 44 outlines the percentage of Texas high school students who attempted suicide in the past 12 months by race and ethnicity for 2001-2017.

Figure 44. Texas High School Students Who Attempted Suicide in the Past 12 Months by Race and Ethnicity, Texas YRBS, 2001-2017[65]



Sexual Identity[66]

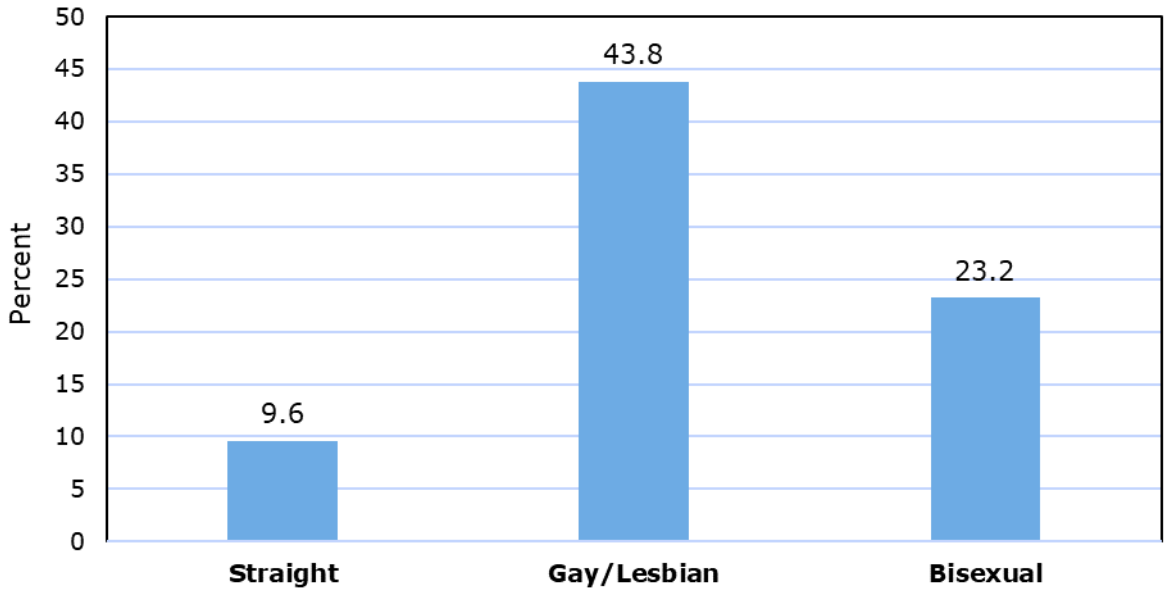
The highest rates of high school students who attempted suicide were seen among students who identify as sexual minorities. The question asking about sexual identity was added in 2015 and Texas does not have 2015 data, resulting in no trend data to date. Students who identified as gay or lesbian were more than four and half times as likely to have attempted suicide as their straight classmates while students who identified as bisexual were nearly two and a half times as likely in 2017. Texas also has the highest suicide attempt rate for gay and lesbian students in the United States.

[65] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

[66] See Table 92 in Appendix A

Figure 45 outlines the percentage of Texas high school students who attempted suicide in the past 12 months by self-identified orientation in 2017.

Figure 45. Texas High School Students Who Attempted Suicide in the Past 12 Months by Self-Identified Sexual Orientation, 2017 Texas, YRBS[67]



Limitations of Youth Risk Behavior Survey Data

Because of the small numbers of students in some racial and ethnic subgroups who participate in any single Texas YRBS, the suicide ideation and attempt estimates may lack precision. The range around the estimate most likely to contain the true value is much broader than it would be with a larger sample size. The survey results are from self-reported data, but research suggests that adolescents are as likely to tell the truth as adults and many steps are taken to remove invalid responses, as well as to demonstrate the confidentiality and importance of the survey to participants. The YRBS is reliant on schools to participate to achieve a necessary participation rate for generalizable data. In 2015, Texas did not achieve the necessary school participation rate, so there is no data for that year. In 2003, the Houston Independent School District (ISD) YRBS sample was part of the statewide sample and Houston ISD did not achieve the necessary participation, so the 2003 Texas data could not be used.

[67] Centers for Disease Control and Prevention, 2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs

4. Suicide Related Statutes

H.B. 3980 states this Summary Report created by the HHSC will list all state statutes related to suicide and suicide prevention, intervention, and postvention. Appendix B lists the pertaining state statutes alphabetically by code area and then in numerical order. These statutes were collected through the work of Denise Brady, JD, for the Texas Suicide Prevention Council in 2015 and, for more recent statutes, research on the legislative library website. Please see Appendix B for a list of these statutes.

Included in this listing are many Education Code statutes relating to issues such as: school staff development; School Health Advisory Councils; health curriculum; and safe, supportive schools. The section on Health and Safety Code concerns establishment of a death review committee, mental health first aid, sharing of data, and early mental health intervention for youth. Further statutes include programs for veterans, standard for juvenile corrections officers, and preventing children from accessing firearms.

5. Policies

H.B. 3980 also states this summary report is to include agency rules and policies related to suicide and suicide prevention, intervention, and postvention. Policies for state agencies were collected from member organizations of the Statewide Behavioral Health Coordinating Council (SBHCC). They are listed exactly as received.

Department of Family and Protective Services

Youth Connection Website

The Department of Family and Protective Services (DFPS) operates a Youth Connection website for older teens and youth who have aged out of the Texas foster care system. This information is contained within the website. The content is governed by statute or rule or policy, rather was determined to be useful information for the population. Content: Suicide Prevention: Struggling with thoughts of suicide or want to help someone who is? National Suicide Prevention Lifeline (1-800-273-8255). You can call or chat online. It is 24/7, free, and confidential support to help you or someone you know who is dealing with depression or thoughts of suicide. There are also special numbers for Spanish speakers: (1-888-628-9454) and the deaf: (1-800-799-4889). Content related to Suicide Prevention was added in September 2017.

DFPS Prevention and Early Intervention 2019 Five Year Plan

Content: As part of the preventing child maltreatment and fatalities, there is a component that will emphasize suicide prevention for teens. In its 2019 Five Year Plan, one of the five strategic plan goals for the DFPS Prevention and Early Intervention program includes the following:

Using these foundational areas to prioritize its work, PEI will continue implementing its five-year strategic plan with special emphasis placed on the following five strategic plan goals:

1. Review and evaluate long-term and emerging trends through the Office of Child Safety, as well as current community and programmatic needs related to preventing child maltreatment and fatalities (Goal 1.2).

PEI will convene a state-wide safety summit with stakeholders, community providers and other state agencies to identify ways PEI can partner with communities to address child fatalities and near fatalities, including those caused by physical abuse, unsafe sleep practices and preventable drownings. Utilizing a public health approach, PEI will focus resources on equipping communities with tools and resources specific to suicide prevention for teens. Additionally, ongoing safety trainings will be provided to increase awareness and safety practices both within communities as well as with providers and home visitors.

DFPS Policy 6420 Rights of Children and Youth in Foster Care

6420 Rights of Children and Youth in Foster Care (CPS October 2017) includes a requirement that CPS staff must provide Form 2530 CPS Rights of Children and Youth in Foster Care to all children and youth in CPS foster care, as required by Social Security Act, Section 475A(b) 42 U.S.C. §675A(b) and Texas Family Code §263.008. It specifies that CPS staff must review Form 2530 with the child and the caregiver no later than 72 hours from the date when: the child comes into foster care; or a placement change is made. Right #36 says that "As a child or youth in foster care I have the right to:

Be involved in decisions about my medical care:

a. I may consent to my own treatment in some cases if allowed by the health care provider. For example, the law allows me to consent to my own counseling for suicide prevention, drug or alcohol problems, or sexual, physical or emotional abuse, and I can agree to be treated for serious contagious or communicable diseases.
b. If I am pregnant and unmarried, I can agree to hospital, medical or surgical treatment, other than abortion, related to the pregnancy. If I have a child who is in my legal care, I can consent to all medical care for my child.
c. If I am 16 years old or older, I have the right to ask a judge to legally authorize me to make some or all of my own medical decisions, such as which kinds of medications I should take."

This policy has been in effect since 2009.

Health and Human Services Commission

26 Texas Administrative Code Part 1, Chapter 301, Subchapter G outlines the contract administration functions of Intellectual or Developmental Disabilities and Behavioral Health Services at HHSC with community mental health services through general provisions, organizational standards, and standards of care.

Rule §301.351 Crisis Services specifically refers to suicide under the documentation of lethality.

Texas Commission on Jail Standards

Suicide Intake Screening Form

The Texas Commission on Jail Standards (TCJS) must create a form for jails to determine at intake whether an inmate may be experiencing mental illness. If affirmative, jail notifies magistrate. This policy has been in effect since 2000.

Training: Assessing for Suicide, Medical, and Mental Impairments.

TCJS developed and delivered training for county jailers in awareness of mental illness. This policy has been in effect from 2013 to 2017.

Mental Health Trainers

TCJS employed trainers, delivering mental health awareness training to county jailers across Texas. Offered through the Texas Commission on Law Enforcement (TCOLE). Extended for 2020 and 2021. This policy has been in effect since 2017.

Prison Safety Fund

Provided funding to enable county jails of 96 beds or less to purchase electronic monitoring equipment for high-risk areas of jail, may include areas housing inmates with mental illness. Later extended to include jails up to 288 beds. TCJS distributed the funding to jails and provided oversight. This policy has been in effect since 2017.

New Suicide Prevention Training

TCJS provides training for county jailers in suicide prevention. Texas Commission on Law Enforcement (TCOLE) course credit. This policy has been in effect in 2020.

Texas Department of Criminal Justice

Administrative Directive 02.15 - Operations of the Emergency Action Center and Reporting Procedures for Serious or Unusual Incidents

The Emergency Action Center (EAC) is responsible for receiving all reports of serious or unusual incidents and notifying appropriate entities and administrative staff. Reported information shall be made available to the Texas Department of Criminal Justice (TDCJ) administration to ensure availability of the necessary information to make critical decisions that affect the safety and security of the public and all divisions of the TDCJ. The EAC operates 24 hours per day, 7 days a week. This policy has been in effect since 1985.

Administrative Directive 06.56 – Procedures for Handling Offenders Identified as Suicide Risks

Establishes guidelines for the referral and handling of offenders identified as suicide risk. Offenders are considered to be suicide risks when behavior appears to have the intent or definite potential of leading to self-inflicted physical harm or death. Staff must immediately and effectively response to suicidal behavior. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual C-20.01 - Training for Correctional Officers

Provide and document ongoing health-related training at least every two years for all correctional officers. There will be annual in-service training on suicide prevention, heat-related illness, HIV/AIDS and Hepatitis. This policy has been in since 1985.

Correctional Managed Health Care Policy Manual A-11.1 - Procedure to be Followed in Cases of Offender Death

Outlines procedures to be followed in the event of an offender's death. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual E-32.1 - Receiving, Transfer and Continuity of Care Screening

Guidelines for immediate identification and treatment of health care needs of offenders through receiving/transfer screening and to provide continuity of care. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual E-35.1 - Mental Health Appraisal for Incoming Offenders

All incoming offenders admitted into the TDCJ will undergo an Intake Mental Health Appraisal by a qualified mental health professional (QMHP) to identify mental health indicators for mental health evaluation referral. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual E-35.2 - Mental Health Evaluation

Mechanism to provide mental health evaluations of offenders identified as having potential mental health needs. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual G-51.6 - Referral of an Offender for Admission to a Behavioral Health Facility

Process for referring offender for crisis management and possible admission into a behavioral health facility as a result of acute mental illness and/or suicidal/self-injurious behavior. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual I-67.1 - Compelled Psychoactive Medication for Mental Illness

Psychoactive medications may be compelled by the treating practitioner for a patient who is imminently dangerous to self or others due to mental illness or at risk of significant deterioration. This policy has been in effect since 1989.

Correctional Managed Health Care Policy Manual G-53.1 - Suicide Prevention Plan

Specialized programming, intervention, training and tracking for the prevention of offender suicide, which includes mental health observation, crisis management, and constant and direct observation. This policy has been in effect since 1995.

Texas Administrative Code Residential Services 163.39 (n) Health Care (3) Health Screening (iii)

Standard relates to questionnaire for health screening where inquiries into and observations of mental health problems, including suicide attempts or ideation are documented. This policy has been in effect since 1997.

Texas Administrative Code Residential Services 163.39 (13) Suicide Prevention

Each facility shall have a written suicide prevention and intervention program reviewed and approved by a qualified medical or mental health professional. All staff with resident supervision responsibilities shall be trained in the implementation of the suicide prevention program. This policy has been in effect since 1997.

Correctional Managed Health Care Policy Manual A-08.9 - The Chronic Mentally Ill Treatment Program - (CMI-TP)

The Chronic Mentally Ill Treatment Program (CMI-TP) is a multidisciplinary program designed to treat and manage the identified chronic mentally ill offender who requires structured monitoring and supervision, in order to further stabilize their mental illness and assist in achieving their highest level of functioning. This policy has been in effect since 2002.

Correctional Managed Health Care Policy Manual A-08.10 - The Program for the Aggressive Mentally Ill Offender (PAMIO)

The program provides mental health evaluation and treatment for the aggressive mentally ill offender. The treatment program utilizes a multi-disciplinary approach through specific therapeutic modalities. The offender is expected to work his way through the program and demonstrate progress. Upon successful completion of the program, treatment staff will make a recommendation to the State Classification

Committee to review the offender for a less restrictive housing assignment. This policy has been in effect since 2002.

Correctional Managed Health Care Policy Manual I-66.3 - Therapeutic Seclusion of Mental Health Patients

Behavioral health facilities may utilize therapeutic seclusion as a special treatment procedure for limited periods of time by physician, psychiatrist/psychiatric mid-level practitioner order.

The use of therapeutic seclusion requires clinical justification and is employed only to protect the patient from self-injury or injury to others. Therapeutic seclusion is not employed as punishment or as a convenience to staff. This policy has been in effect since 2002.

Executive Directive 02.17 - Serious Incident Reviews

The TDCJ will conduct a serious incident review for a serious or unusual incident involving TDCJ offenders and staff, as deemed necessary by the executive director. The review shall examine all aspects of the situation, determine the findings, and offer recommendations to the executive director for corrective action. This policy has been in effect since 2003.

American Correctional Association (ACA) Standards for Adult Correctional Institutions 4th and 5th Edition

Mental Health Program 4368 & 4369, Mental Health Screen 4370, Mental Health Appraisal 4371, Mental Health Evaluations 4372, Suicide Prevention and Intervention 4373. This policy has been in effect since 2003.

Standard Operating Procedures John T Montford Psychiatric/Medical Unit Texas Tech University Health Sciences Center (TTUHSC) SOP: JMP-043

Inpatient Treatment Program - Offenders may need short-term or extended hospitalization in a Behavioral Health Facility because of acute mental illness and/or suicidal/self-injurious behavior. This policy has been in effect since 2004.

Laundry Necessities Procedure Manual 19.08 - Suicide Blankets

Establishes that Laundry has the responsibility to launder suicide blankets as requested by medical. Also, that the laundry department shall not make repairs to the suicide blankets. These blankets must be returned to the vendor. This policy has been in effect since 2005.

Security Memorandum 05.20 - Responding to an Offender Suicide or Attempted Suicide

Establishes a policy that staff shall immediately respond to an offender who is threatening or appears to be attempting suicide.

Staff shall make every effort to prevent an offender from attempting suicide and shall obtain immediate medical and/or mental health assistance for the offender. This policy has been in effect since 2007.

University of Texas Medical Branch (UTMB) Correctional Managed Care (CMC) Mental Health Services Departmental Policy Manual - MHS B-3 - Suicide Prevention

Provides specialized programming, intervention and training on the prevention of offender suicide. This policy has been in effect since 2007.

Youthful Offender Program (YOP) - Champion Program Operations Manual (CYPOM) 02.06 – "Suicide Prevention, Risk, and Reporting"

Policy provides an overview for the Champion program staff concerning appropriate suicide prevention training, risk identification, notification, documentation, and reporting. This policy has been in effect since 2008.

Reentry and Integration Division – Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Program Guidelines and Processes, PGP 01.02 Intensive Case Management

Each contracted Local Mental Health Authority (LMHA) is required to provide 24/7 crisis intervention services to offenders enrolled in case management. This policy has been in effect since 2009.

Reentry and Integration Division - TCOOMMI, Program Guidelines and Processes, PGP 01.07 Transitional Case Management

Each contracted Local Mental Health Authority (LMHA) is required to provide 24/7 crisis intervention services to offenders enrolled in case management. This policy has been in effect since 2009.

Safe Prisons/PREA Operations Manual, 07.01 - Visual Tracking Grid

Establishes a procedure and guidelines for maintaining a Visual Tracking Grid (VTG) of the unit to pinpoint locations of Safe Prisons/PREA related incidents occurring on the unit. The VTG provides a visual display of incidents to provide staff with awareness related to patterns, trends, times, and locations. This policy has been in effect since 2011.

Serious Violent Offender Reentry Initiative (SVORI) Program Operations Manual, SVORI 04.07 – Role Of Security Staff In SVORI

Policy provides an overview for the SVORI program staff concerning safety and security objectives to include suicide reporting procedures. This policy has been in effect since 2011.

Correctional Managed Health Care Policy Manual G-52.3 - Admission to the TDCJ Mental Health Therapeutic Diversion Program (MHTDP)

The MHTDP program targets offenders with mental health issues such as adjustment disorders, mood (depressive and bipolar disorder), anxiety (panic disorder, post-traumatic stress disorder (PTSD) and other anxiety disorders), impulse control disorders (intermittent explosive disorder and other emotional and behavioral difficulties resulting in emotional liability and behavioral dyscontrol). Participants receive both individual and group therapy designed to improve the offender's decision making, impulse control and quality of life. This policy has been in effect since 2014.

Our Roadway To Freedom Program (ORTF) Operations Manual 04.07 – "Role Of Security Staff In ORTF"

Policy provides an overview for the ORTF program staff concerning safety and security objectives to include suicide reporting procedures. This policy has been in effect since 2014.

Reentry and Integration Division, Program Guidelines and Processes, PGP 02.03 Release Processing

Each releasing offender is provided resources to assist post-release which includes the national suicide prevention hotline. This policy has been in effect since 2015.

National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons, P-B-05 - Suicide Prevention and Intervention

Suicides are prevented when possible by implementing prevention efforts and intervention. This policy has been in effect since 2018.

National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons, P-E-05 - Mental Health Screening and Evaluation

Mental health screening is performed to ensure that urgent mental health needs are met. This policy has been in effect since 2018.

Female Cognitive Pre-Release Program (FCPRP) Operations Manual, FCPRP 04.02 – Role Of Security Staff In Female Cognitive Pre-Release Program (FCPRP)

Policy provides an overview for the FCPRP program staff concerning safety and security objectives to include suicide reporting procedures. This policy has been in effect since 2019.

Texas Juvenile Justice Department

CMS 01.13: Mental Health Screening and Psychological Evaluation

Agency internal policy which includes use of the suicide risk screening for orientation and assessment. In effect for three years.

CMS 06.71: Suicide Alert Procedures for High-Restriction Facilities

Agency internal policy for assessing, treating, and responding to youth with suicidal ideations and behaviors at the secure facilities. In effect for four years.

CMS 06.73: Suicide Alert Procedures for Medium-Restriction Facilities

Agency internal policy for assessing, treating, and responding to youth with suicidal ideations and behaviors at the halfway houses. In effect for four years.

GAP 380.9187: Suicide Alert Definitions

General Administrative Policy pertaining to defining suicide related terms used in the Texas Juvenile Justice Department (TJJD) suicide prevention policies. In effect for ten years.

GAP 380.9188: Suicide Alert for High-Restriction Facilities

General Administrative Policy pertaining to procedures for identification, assessment, treatment, and protection of youth in secure facilities that may be at risk for suicide. In effect for ten years.

GAP 380.9189: Suicide Alert for Medium-Restriction Facilities

General Administrative Policy pertaining to procedures for identification, assessment, treatment, and protection of youth in halfway houses that may be at risk for suicide. In effect for ten years.

GAP 380.9190: Suicide Prevention for Parole

General Administrative Policy for procedures for the protection of youth on parole in the community who may be at risk for suicide. In effect for ten years.

CMS 12.61: Suicide Prevention Procedures for Youth on Parole

Agency internal policy for parole staff awareness and response to parole youth engaging in suicide behavior or ideation. In effect for four years.

Texas Military Department

Draft Operations Order for FY20/21 for National Guard

Family Support Services (FSS) will develop Intervention Officer (SIO) with Applied Suicide Intervention Skills Training (ASIST) training and marketing plan in order to improve SIO/ASIST compliance. FSS will develop Master Resilience Trainer (MRT) training and marketing plan and acquire addition funding for Texas Military Department (TMD) counselors to sustain resiliency.

Army Regulation 600-63- Army Health Promotion

Directs implementation of Community Health Promotion Program aimed to enhance readiness and reduce suicidal behaviors. In effect seven years. Revised in 2016.

H.B. 1025, 83rd Legislature, Regular Session, 2013

Creates the TMD Mental Health Initiative (Counseling team). In effect six years.

H.B. 1 Rider 28,_86th Legislature, Regular Session, 2019

Limits TMD Mental Health Initiative (Counseling team) clients to military members. In effect less than one year.

Army Regulation 600_85- Army Substance Abuse Program (Ch 12)

Directs units to conduct Unit Risk Inventories at least annually (suicidal thoughts/activity are included in the survey) This policy has been in effect three years. Policy was updated in 2016.

Department of Army (DA) Pamphlet 600-24- Health Promotion, Risk Reduction, and Suicide Prevention

Explains procedures for health promotion, risk reduction, and suicide prevention efforts to mitigate high-risk behaviors. In effect four years.

IMPORTANT ARMY PROGRAMS: SEXUAL HARASSMENT/ASSAULT RESPONSE AND PREVENTION, EQUAL OPPORTUNITY, SUICIDE PREVENTION, ALCOHOL AND DRUG ABUSE PREVENTION, AND RESILIENCE

Provides guidance for a more effective method of training, emphasizing leader involvement, and leveraging the Army's culture to improve the outcomes of these valuable programs to enhance the readiness and welfare of our Soldiers and units. In effect less than one year.

Texas Tech University Health Sciences Center

TTUHSC Operating Policy: HSC OP 70.38, Employee Assistance Program

This policy establishes the procedures governing the use of and referral to the Employee Assistance Program (EAP). The policy also allows EAP to provide wellness workshops on select topics. Suicide prevention programs such as Question, Persuade, and Refer (QPR) and Mental Health First Aid (MHFA) have been offered as requested. The policy has been in effect since 1991.

Texas Veteran Commission

Government Code, § 434.038, requires the Texas Veteran Commission (TVC) to coordinate with the Department of State Health Services to incorporate a suicide prevention component as part of the accreditation training and examination for county veteran service officers.

Government Code, § 434.351 – § 434.401, specify TVC's requirements related to statewide coordination for the mental health program for veterans (MHPV) and the community collaboration initiative related to MHPV.

6. Programs

House Bill 3980 requires a description of state agency initiatives since 2000 to address suicide and include the following information relating to each initiative: the administering state agency; the funding sources, including whether the funding was provided by: a federal block grant; a federal discretionary grant; or state appropriations; the years of operation; and whether the initiative is an example of a community-based effort to address suicide. Programs were collected from agency members of the SBHCC and are reported as provided.

Department of State Health Services

Texas Youth Suicide Prevention Grant

Grant project for three years with three partners to increase services and referrals for youth when identified as being at risk for suicide. Partners included Mental Health America Texas, Air Force Base Medical Center in San Antonio Pediatric Clinic and Bexar County Center for Health Services LMHA.

Years Funded	Community Based Intervention
FY2008-FY2011	This is an example of community-based intervention.

Table 1: Funding for FY2008-FY2011 Texas Youth Suicide Prevention Grant

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$470,000	$470,000	$470,000	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$470,000**	**$470,000**	**$470,000**	**$0**	**$0**

Zero Suicide Texas Grant (ZEST)

The goals of the ZEST initiative were to improve identification, treatment and support services for high risk youth by creating Suicide Safe Care Centers within the public mental health system; expanding and coordinating these best practice suicide prevention activities with other youth-serving organizations and community partners to create Suicide Safe Care Communities; and implementing research-informed training and communications efforts to create a Suicide Safe Care State.

Years Funded

FY2012-FY2016

Community Based Intervention

This is an example of community-based intervention.

Table 2: Funding for FY2012-FY2016 Zero Suicide Texas Grant (ZEST)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$440,000	$440,000	$189,000	$251,000
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$440,000**	**$440,000**	**$189,000**	**$251,000**

Statewide Suicide Plan and Programs

With support from the Maternal/Child Health (MCH) Block Grant, the program was able to host a Symposium to raise public awareness, train providers and educate in suicide prevention best practices from national experts. Further new tools were developed, such as an update of the Tx State Plan for Suicide Prevention, Suicide Safer Schools toolkit and model and suicide prevention Apps, webpage, toolkit and one pagers to address evidence based, and best practice based suicide prevention needs for stakeholders.

Years Funded

FY2012-FY2016

Community Based Intervention

This is an example of community-based intervention.

Table 3: Funding for FY2012-FY2016 Statewide Suicide Plan and Programs

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$175,000	$200,000	$1,000,000	$889,000	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$175,000**	**$200,000**	**$1,000,000**	**$889,000**	**$0**

Signs of Suicide (SOS)

SOS is a universal, school-based depression awareness and suicide prevention program designed for middle-school (ages 11-13) and high-school (13-17) students. Designated as a program with evidence of effectiveness.

Years Funded

FY2015-FY2019

Community Based Intervention

This is not an example of community-based intervention.

Table 4: Funding for FY2015-FY2019 Signs of Suicide

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$18,428	$47,058	$45,962	$56,856	$18,626
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$18,428**	**$47,058**	**$45,962**	**$56,856**	**$18,626**

Signs of Suicide (SOS)

SOS is a universal, school-based depression awareness and suicide prevention program designed for middle-school (ages 11-13) and high-school (13-17) students. Designated as a program with evidence of effective-ness.

Years Funded

FY2020

Community Based Intervention

This is not an example of community-based intervention.

Table 5: Funding for FY2020 Signs of Suicide (SOS)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$25,000	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$25,000**	**$0**	**$0**	**$0**	**$0**

Texas Commission on Jail Standards

Suicide Intake Screening Form

Form for jails to determine at intake whether an inmate may be experiencing mental illness. If affirmative, jail notifies magistrate.

Years Funded

FY2020, FY2015.
No budget line item.
Funded with existing funds.

Community Based Intervention

This is not an example of community-based intervention.

Table 6: Funding for FY2020, FY2015 Suicide Intake Screening Form

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Training: Assessing for Suicide, Medical, and Mental Impairments

Training for county jailers in awareness of mental illness.

Years Funded

FY2013 - FY2017.
No budget line item.
Funded with existing funds.

Community Based Intervention

This is not an example of community-based intervention.

Table 7: Funding for FY2013 - FY2017 Training: Assessing for Suicide, Medical, and Mental Impairments

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Mental Health Trainers

TCJS employed trainers, delivering mental health awareness training to county jailers across Texas. Offered through TCOLE. Extended for 2020 and 2021.

Years Funded

FY2017 - FY2019.

Community Based Intervention

This is not an example of community-based intervention.

Table 8: Funding for FY2017 - FY2019 Mental Health Trainers

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$176,022	$158,416	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$176,022**	**$158,416**	**$0**	**$0**	**$0**

Prison Safety Fund

Funding to enable county jails of 96 beds or less to purchase electronic monitoring equipment for high-risk areas of jail, may include areas housing inmates with mental illness. Later extended to include jails up to 288 beds.

Years Funded

FY2018.
Extended to FY2019.

Community Based Intervention

This is not an example of community-based intervention.

Table 9: Funding for FY2018 Extended to FY2019 Prison Safety Fund

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$59,710	$247,506	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$59,710**	**$247,506**	**$0**	**$0**	**$0**

New Suicide Prevention Training

Training for county jailers. TCOLE course credit.

Years Funded

Begins 2020.
No budget line item.
Funded with existing funds.

Community Based Intervention

This is not an example of community-based intervention.

Table 10: Funding for New Suicide Prevention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Texas Veterans Commission

Veterans Mental Health Department (VMHD)

The focus for the VMHD IAC with HHSC begins by training Military Veteran Peer Network (MVPN) Peer Service Coordinators and MVPN Peers in trauma affected veterans issues. The intent of this strategy is to continue to advocate for and foster a greater ability to serve the behavioral health needs of Texas Veterans.

Additionally, the VMHD focuses on: identifying, training, and communicating with licensed mental health providers who provide clinical services to military trauma-affected service members, veterans, and their families (SMVF); engaging with community- and faith-based organizations which serve SMVF to provide military-informed care training and encourage participation in community collaborations; and coordinating efforts across the Texas criminal justice system to create more effective diversion and treatment services for justice involved veterans.

Years Funded

FY2015-FY2019.

Community Based Intervention

This is an example of community-based intervention.

Table 11: Funding for FY2015-FY2019 Veterans Mental Health Department (VMHD)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$263,984	$463,814	$443,365	$457,764	$268,259
Other	$0	$0	$0	$0	$0
Sub-total	**$263,984**	**$463,814**	**$443,365**	**$457,764**	**$268,259**

Texas Juvenile Justice Department

Collaborative Assessment and Management System (CAMS)

CAMS is an evidence-based therapeutic framework for suicide specific assessments of patient's suicidal risk. The clinician and patient engage in an interactive assessment process and the patient is actively involved in the development of their own treatment plan.

Years Funded

FY2020.

Community Based Intervention

This is an example of community-based intervention.

Table 12: Funding for FY2020 Collaborative Assessment and Management System (CAMS)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$10,000	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$10,000**	**$0**	**$0**	**$0**	**$0**

Zero Suicide Institute

It implements an approach that includes evidence-based practices for suicide prevention, coordinating trainings and adopting continuous quality improvement efforts prevention-commitment to comprehensive suicide safer care. Works with QPR and CAMS by training staff on new modernized instruments to improve current suicide assessments and treatment.

Years Funded

FY2020.

Community Based Intervention

This is an example of community-based intervention.

Table 13: Funding for FY2020 Zero Suicide Institute

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$30,000	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$30,000**	**$0**	**$0**	**$0**	**$0**

QPR - Training for Trainers

Training for trainers and mental health professionals.

Years Funded

FY2019.

Community Based Intervention

This is not an example of community-based intervention.

Table 14: Funding for FY2019 QPR - Training for Trainers

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$29,278	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$29,278**	**$0**	**$0**	**$0**	**$0**

Wellness Project - Well Bed System

An electronic wellness check system where coaches virtually log their check ins of youth and enhances accountability of check ins for youth on suicide watch.

Years Funded

FY2020.

Community Based Intervention

This is not an example of community-based intervention.

Table 15: Funding for FY2020 Wellness Project - Well Bed System

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$444,445	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$444,445**	**$0**	**$0**	**$0**	**$0**

Texas Department of Criminal Justice[68]

Emergency Action Center (EAC)

The Emergency Action Center (EAC) is responsible for receiving all reports of serious or unusual incidents and notifying appropriate entities and administrative staff. Reported information shall be made available to the TDCJ administration to ensure availability of the necessary information to make critical decisions that affect the safety and security of the public and all divisions of the TDCJ. The EAC operates 24 hours per day, 7 days a week. (Formulated in 1985).

Years Funded

FY2020-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 16: Funding for FY2020-Present Emergency Action Center (EAC)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

[68] No funding information is available for TDCJ because funding was tied to other initiatives and could not be easily determined.

Correctional Officer - Suicide Prevention Training

In accordance with Correctional Managed Health Care Policy C-20.1 - Training for Correctional Officers, training in suicide prevention, heat-related illness, HIV/AIDS and Hepatitis is conducted and documented annually. (Formulated in 1985).

Years Funded

FY2020-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 17: Funding for FY2020-Present Correctional Officer - Suicide Prevention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Assessments and Referral to Mental Health Services

Newly arrived offenders are screened for emergent medical and mental health needs immediately upon arrival by a member of health services staff. Offenders with urgent mental health needs are immediately referred to a mental health professional. A mental health appraisal that includes a structured interview is performed on all offenders within 14 days of arrival. A comprehensive mental health evaluation is conducted by a qualified mental health professional within 14 days of referral. (Formulated in 1985).

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 18: Funding for FY2000-Present Assessments and Referral to Mental Health Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Crisis Management

Offenders who present a significant and imminent danger to themselves are moved to Crisis Management at one of the psychiatric hospitals, Clements Unit or Mt. View Unit. Offenders who have mental health needs that cannot be met on an outpatient unit are moved to one of the psychiatric hospitals, Jester IV, Montford or Skyview. The inpatient facilities are designed and staffed to provide more intense diagnostics, treatment, monitoring and to manage more acute mental illness. (Policies dating back to at least 1985).

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 19: Funding for FY2000-Present Crisis Management

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TDCJ Suicide Prevention Task Force

Suicide Prevention Working Group: Monthly meetings are held to discuss events leading up to, surrounding, and following a suicide. Appropriate recommendations for unit practices and future training initiatives are discussed to further aid in the prevention and response to suicide.

Annual Suicide Review Meeting: An annual meeting reviewing all suicides is conducted by agency staff and university medical providers. Based on the analysis of each suicide, policies and practices are reviewed and discussed to offer improvements in preventing suicides.

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 20: Funding for FY2000-Present TDCJ Suicide Prevention Task Force

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Correctional Managed Health Care Committee (CMHCC) Joint Morbidity and Mortality Suicide Subcommittee

This group membership consists of psychiatrists and doctoral level psychologist appointed by the university Medical Directors and the TDCJ Health Services Division Director. This group is charged with the ongoing review of each TDCJ offender suicide from a clinical perspective to assess the quality of health care rendered in each case and identify trends that may assist in further development of additional suicide prevention measures. This group meets on a monthly basis. (Formulated in 1994).

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 21: Funding for FY2000-Present Correctional Managed Health Care Committee (CMHCC) Joint Morbidity and Mortality Suicide Subcommittee

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TDCJ Office of Mental Health Monitoring and Liaison (OMHML) Suicide Monitoring Activities

Review on offender suicide and corrective action plans. Maintain statistical suicide data.

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 22: Funding for FY2000-Present TDCJ Office of Mental Health Monitoring and Liaison (OMHML) Suicide Monitoring Activities

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Mental Health First Aid Training

Mental Health First Aid (MHFA) Training is conducted by Certified MHFA Instructor for all medical and behavioral staff at the John T. Montford Unit. (Formulated in 1994).

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 23: Funding for FY2000-Present Mental Health First Aid Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Intensive Crisis Counseling - Outpatient Services

Offenders who are identified as possible risk for suicide and/or present in a crisis will be offered intensive crisis counseling by a qualified mental health professional (QMHP). QMHP will use Cognitive Therapy, Strategic/Solution Focused Therapy, and Reality Therapy strategies to lessen patient's response to precipitating events. (Formulated in 1994).

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 24: Funding for FY2000-Present Intensive Crisis Counseling - Outpatient Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Transitional Success Group Treatment (TSG) on Intake Facilities

Texas Tech University Health Sciences Center (TTUHSC) - Group programming on intake facilities focused on successful transition into TDCJ. Addresses depression management, suicide prevention, and adjusting to correctional environment by using effective coping strategies. (Formulated in 1994).

Years Funded

FY2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 25: Funding for FY2000-Present Transitional Success Group Treatment (TSG) on Intake Facilities

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Staff Training

The agency has increased both Pre-Service and In-Service crisis intervention and mental health response training for correctional and parole staff. Officer training also includes content specific to suicide prevention and response. Pre-Service Training and annual In-Service Training include Crisis Intervention/Mental Health training.

Years Funded

FY2002-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 26: Funding for FY2002-Present Intensive Crisis Counseling - Outpatient Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Specialized Psychiatric Treatment Programs

Specialized psychiatric treatment programs for offender patients assigned to high security that do not require acute care inpatient psychiatric therapy have been instituted at the Clements Unit. The Program for the Aggressive Mentally Ill Offender (PAMIO) provides evaluation and treatment of mentally ill offenders with aggressive behavior. There are also two programs for the Chronically Mentally Ill (CMI) offenders, Inpatient CMI and Outpatient CMI.

Years Funded

FY2002-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 27: Funding for FY2002-Present Specialized Psychiatric Treatment Programs

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

University of Texas Medical Branch (UTMB) Unit-Level Suicide Prevention and Intervention Training

Suicide Prevention training is conducted with unit UTMB Mental Health Staff in accordance with American Correctional Association (ACA) Standard 4373.

Years Funded

FY2003-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 28: Funding for FY2003-Present University of Texas Medical Branch (UTMB) Unit-Level Suicide Prevention and Intervention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

University of Texas Medical Branch (UTMB) Suicide Prevention Training

Suicide Prevention training is conducted with UTMB Mental Health Staff in accordance with UTMB Correctional Managed Care (CMC) Mental Health Services Department Policy Manual, Policy MHS B-3. Training is done at the following levels: regional, online, and annually at the UTMB CMC annual meeting.

Years Funded

FY2007-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 29: Funding for FY2007-Present University of Texas Medical Branch (UTMB) Suicide Prevention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Rehabilitation Programs

The TDCJ operates a number of rehabilitation programs to include Youthful Offender Program (YOP) Champion Program, Female Cognitive Pre-Release Program (FCPRP), Serious Violent Offender Reentry Initiative (SVORI) Program, and Our Roadway to Freedom (ORTF). Each of these programs has policies in place concerning suicide prevention, identification, notification, documentation and reporting.

Years Funded

FY2008-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 30: Funding for FY2008-Present Rehabilitation Programs

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

Each contracted Local Mental Health Authority (LMHA) is required by TCOOMMI policy to provide 24/7 crisis intervention services to offenders enrolled in case management.

Years Funded

FY2009-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 31: Funding for FY2009-Present Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Regional Incident Reviews

A Regional Incident Review is conducted following an offender suicide, by an assembled team of staff not assigned to the unit at which the suicide occurred. The team reviews the circum-stances of the incident including, but not limited to, a review of security procedures, correctional officer staffing, health services, physical plant and classification to identify any issues or trends which may prevent future occurrences.

Years Funded

FY2010-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 32: Funding for FY2010-Present Regional Incident Reviews

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Office of Inspector General Suicide Review

All in-custody deaths that are not physician attended deaths by natural causes or execution are referred to the Office of Inspector General for review and investigation as deemed appropriate.

Years Funded

FY2010-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 33: Funding for FY2010-Present Office of Inspector General Suicide Review

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Employee Information Pocket Card

Provides staff with different scenarios that could indicate: Suicide High Risk Factors, Warning Statement, Signs an Offender Might be Suicidal, or Mood Changes.

Years Funded

FY2012-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 34: Funding for FY2012-Present Employee Information Pocket Card

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Mental Health Therapeutic Diversion Program (MHTDP)

The MHTDP program targets offenders with mental health issues such as adjustment disorders, mood (depressive and bipolar disorder), anxiety (panic disorder, PTSD and other anxiety disorders), impulse control disorders (intermittent explosive disorder and other emotional and behavioral difficulties resulting in emotional liability and behavioral dyscontrol). Participants receive both individual and group therapy designed to improve the offender's decision making, impulse control and quality of life.

Years Funded

FY2014-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 35: Funding for FY2014-Present Mental Health Therapeutic Diversion Program (MHTDP)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Reentry Initiatives

Each releasing offender is provided resources to assist post-release which includes the national suicide prevention hotline.

Years Funded

FY2015-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 36: Funding for FY2015-Present Reentry Initiatives

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Online Distance Learning Course 1020 - Non-Violent Crisis Intervention

On-line distance learning class is provided for licensed counselors to receive continuing education. The curriculum provides an overview of crisis intervention and offers valuable information such as suicide prevention, risk identification, and notification.

Years Funded

FY2015-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 37: Funding for FY2015-Present Online Distance Learning Course 1020 - Non-Violent Crisis Intervention

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Incoming Offender Flyer

Provides incoming offenders with different scenarios that could indicate: Suicide High Risk Factors, Warning Statement, Signs an Offender Might be Suicidal, or Mood Changes.

Years Funded

FY2017-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 38: Funding for FY2017-Present Incoming Offender Flyer

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

New Arrival Orientation Packet

Offenders reporting to parole as a new arrival are provided a resource packet which includes the 24/7 crisis hotline phone number.

Years Funded

FY2019-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 39: Funding for FY2019-Present New Arrival Orientation Packet

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Executive Level Suicide Review Team

A team comprised of senior staff conducts an extensive review of each suicide to include staff and offender interviews, policy reviews, and provides recommendations to executive leadership.

Years Funded

FY2019-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 40: Funding for FY2019-Present Executive Level Suicide Review Team

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Health and Human Services Commission

Resilient Youth - Safer Environments (RYSE)

This SAMSHA funded grant creates comprehensive Suicide Safer Early Intervention and Prevention (SSIP) systems to support youth serving organizations, including Texas schools, mental health programs, educational institutions, juvenile justice systems, substance abuse programs, and foster care systems.

The target population, youth ages 10 to 24 years at elevated risk of suicide and suicide attempts, will receive enhanced services through best practice trainings, improved suicide care in clinical early intervention, and effective programming and treatment services in Hurricane Harvey and Sante Fe ISD schools.

Years Funded

FY2020-FY2024.

Community Based Intervention

This is an example of community-based intervention.

Table 41: Funding for FY2020-FY2024 Resilient Youth - Safer Environments (RYSE)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$736,000	$736,000	$736,000	$736,000	$736,000
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$736,000**	**$736,000**	**$736,000**	**$736,000**	**$736,000**

Suicide Care Initiative (SCI)

SCI will work through Local Mental Health Authorities (LMHAs) and Local Behavioral Health Authorities (LBHAs) with schools, faith-based organizations, primary care, and hospitals to implement a Zero Suicide framework through three collaborative projects reaching individuals at any stage in their suicide care journey. The Zero Suicide framework refers to a system-wide organizational commitment to safer suicide care in health and behavioral health care systems. The following four LMHA pilot sites will oversee the development, implementation and evaluation of SCI projects through the grant funding provided:

- The Harris Center for Mental Health;
- Integral Care;
- Mental Health and Mental Retardation(MHMR) of Tarrant County; and
- Tropical Texas Behavioral Health.

Years Funded

FY2020.

Community Based Intervention

This is an example of community-based intervention.

Table 42: Funding for FY2020 Suicide Care Initiative (SCI)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$2,000,000	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$2,000,000**	**$0**	**$0**	**$0**	**$0**

Psychiatric Emergency Services Centers (PESC): crisis stabilization units, extended observation units, crisis residential units, and crisis respite units.

PESCs are available 24/7 and include prompt face-to-face crisis assessments, crisis intervention services, and crisis follow-up and relapse prevention services in a residential setting. PESCs may be staffed with mental health providers, peer providers, substance use disorder providers, medical professionals, or other professionals that offer assessment, support, and services to achieve psychiatric stabilization to individuals with behavioral health issues.

Years Funded

FY2008-Present.

Community Based Intervention

This is an example of community-based intervention.

Table 43: Funding for FY2008-Present Psychiatric Emergency Services Centers (PESC): crisis stabilization units, extended observation units, crisis residential units, and crisis respite units.

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	Unknown	Unknown	$20,027,445	$19,700,611	$17,691,123
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$20,027,445**	**$19,700,611**	**$17,691,123**

Mobile Crisis Outreach Team (MCOT)[69]

MCOT services provide a combination of services including emergent and urgent care, crisis follow-up, and relapse prevention to child, youth or adults in the community 24 hours a day, 7 days a week, every day of the year. The team provides psychiatric emergency care in the community to begin the process of assessment and definitive treatment.

Years Funded

FY2008-Present.

Community Based Intervention

This is an example of community-based intervention.

Table 44: Funding for FY2008-Present Mobile Crisis Outreach Team (MCOT)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	Unknown	Unknown	Unknown	Unknown	Unknown
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

[69] HHSC did not provide dollar amounts for this program beyond stating it was funded by general revenue.

Crisis Hotline Services[70]

The Crisis Hotline is a continuously available telephone services that provides crisis screening and assessment, crisis intervention services, mental health and substance use referrals and general mental health and substance use information to callers 24 hours a day, 7 days a week, every day of the year.

Years Funded

FY2008-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 45: Funding for FY2008- Crisis Hotline Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	Unknown	Unknown	Unknown	Unknown	Unknown
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0

[70] HHSC did not provide any funding amount, just the funding source.

National Suicide Prevention Lifeline (NSPL)

Four Local Mental Health Authorities (The Harris Center, Emergence Health Network, Integral Care, and MHMR of Tarrant County) participate as NSPL members within a national network of local crisis centers that provides free and confidential emotional support to people in suicidal or emotional distress 24 hours a day, 7 days a week.

Years Funded

FY2020-FY2021.

Community Based Intervention

This is an example of community-based intervention.

Table 46: Funding for FY2020-FY2021 National Suicide Prevention Lifeline (NSPL)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$1,513,529	$1,567,276	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$1,513,529**	**$1,567,276**	**$0**	**$0**	**$0**

Private Purchased Beds/Community Mental Health Hospital beds[71]

HHSC currently contracts with Local Mental Health Authorities (LMHAs)/ Local Behavioral Health Authorities (LBHAs), for provision of inpatient level of care in the community under the G.2.2. Community Hospital strategy. The funding strategy and reporting requirements on HHSC funded beds can be grouped into two primary categories: first, the Community Mental Health Hospital (CMHH) beds and second the Private Purchased Beds (PPBs).

Years Funded	Community Based Intervention
FY2020-Present.	This is not an example of community-based intervention.

Table 47: Funding for FY2020-Present Private Purchased Beds/Community Mental Health Hospital beds

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	Unknown	Unknown	Unknown	Unknown	Unknown
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

[71] HHSC did not provide dollar amounts for this program beyond stating it was funded by general revenue.

Texas Targeted Opioid Response (TTOR)

TTOR requires certain funded providers to participate to participate in suicide prevention training since suicide is correlated with opioid overdose.

Years Funded

FY2019-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 48: Funding for FY2019-Present Executive Level Suicide Review Team

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Texas Prevention Training (TPT)

The Texas Prevention Training (TPT) contract provides a statewide coordinated system of substance use and misuse prevention training and technical assistance services to support and enhance workforce development in Texas. Training will be based on the latest substance use and misuse prevention research technology and best practice approaches in order to support the effective implementation of evidence-based prevention programs across the State.

Years Funded

FY2020-Present.
(*5-year contract term)

Community Based Intervention

This is an example of community-based intervention.

Table 49: Funding for FY2020-Present Texas Prevention Training (TPT)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Substance Use and Misuse Prevention - Youth Prevention Programs (YP)

Prevention services are holistic in nature. They include topics related to substance use and misuse prevention, but also pertain to behavioral and mental health promotion, which includes suicide prevention. Suicide prevention is addressed in the community through information dissemination; activities such as presentations, informative materials, and social media messaging, etc.

Years Funded

FY2014-Present.
(*five-year contract term)

Community Based Intervention

This is not an example of community-based intervention.

Table 50: Funding for FY2019-Present Executive Level Suicide Review Team

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$10,666	$10,666	$10,666	$10,666	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$10,666**	**$10,666**	**$10,666**	**$10,666**	**$0**

Substance Use and Misuse Prevention Community Coalition Partnerships (CCP)

Prevention services are holistic in nature. They include topics related to substance use and misuse prevention, but also pertain to behavioral and mental health promotion, which includes suicide prevention. Suicide prevention is addressed in the community through information dissemination; activities such as presentations, informative materials, and social media messaging, etc.

Years Funded

FY2014-Present.
(*5-year contract term)

Community Based Intervention

This is not an example of community-based intervention.

Table 51: Funding for FY2014-Present Substance Use and Misuse Prevention Community Coalition Partner-ships (CCP)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Substance Use Treatment Services

State licensed treatment and other community agencies deliver services to youth and adults identified as eligible for treatment services.

Years Funded

FY2005-FY2009;
FY2010-FY2015;
FY2016-FY2020

Community Based Intervention

This is an example of community-based intervention.

Table 52: Funding for FY2005-FY2009; FY2010-FY2015; FY2016-FY2020 Substance Use Treatment Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Recovery Support Services

Services are provided to individuals with a history of alcohol and/or drug use, including co-occurring mental health disorders, who are in or seeking recovery, along with their family members, significant others, and supportive allies. Non-clinical services that assist individuals and families to recover from alcohol, drugs (illicit and legal), or co-occurring substance use.

Years Funded

FY2013-FY2019.

Community Based Intervention

This is an example of community-based intervention.

Table 53: Funding for FY2013-FY2019 Recovery Support Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Substance Use Intervention Services - Outreach, Screening, Assessment and Referral (OSAR), Pregnant-Post-partum, Parenting Awareness and Drug Risk Education (PADRE), Rural Border

Intervention services are intended to interrupt the onset or progression of substance misuse through targeted programs that address specific populations and risk factors. Services include completing an assessment and development of a service plan. The contactor will refer and conduct case management activities to address the needs of the client. Contractors establish memorandums of agreements with their communities service providers for those services they do not provide directly.

Years Funded

FY2005-FY2009;
FY2010-FY2015;
FY2016-FY2020

Community Based Intervention

This is an example of community-based intervention.

Table 54: Funding for FY2005-FY2009; FY2010-FY2015; FY2016-FY2020 Substance Use Intervention Services - Outreach, Screening, Assessment and Referral (OSAR), Pregnant-Post-partum, Parenting Aware-ness and Drug Risk Education (PADRE), Rural Border

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Substance Use and Misuse Prevention - Prevention Resource Centers (PRC)

Prevention services are holistic in nature. They include topics related to substance use and misuse prevention, but also pertain to behavioral and mental health promotion, which includes suicide prevention.

Suicide prevention is addressed in the community through information dissemination; activities such as presentations, informative materials, and social media messaging, etc.

Years Funded

FY2014-Present.

Community Based Intervention

This is an example of community-based intervention.

Table 55: Funding for FY2014-Present Substance Use and Misuse Prevention - Prevention Resource Centers (PRC)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Appendix A. Data Tables

Mortality

Table 56. Texas Suicide Mortality, Number and Rate per 100,000 Population, 2000-2017[72]

Year	Number	Rate
2000	2,048	9.8
2001	2,221	10.4
2002	2,307	10.6
2003	2,358	10.7
2004	2,293	10.2
2005	2,410	10.6
2006	2,344	10.0
2007	2,432	10.2
2008	2,547	10.5
2009	2,806	11.3
2010	2,886	11.5
2011	2,887	11.2
2012	3,029	11.6
2013	3,054	11.5
2014	3,248	12.0
2015	3,400	12.4
2016	3,477	12.5
2017	3,769	13.3

[72] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Age Group

Table 57. Suicide Mortality in Youth and Young Adults, Texas 2000-2017[73]

Years	5-14 years Numbers	5-14 years Rate	15-24 years Numbers	15-24 years Rate
2000	33	1.0	339	10.7
2001	28	0.8	326	10.0
2002	24	0.7	322	9.6
2003	24	0.7	348	10.2
2004	20	0.6	334	9.7
2005	22	0.6	367	10.5
2006	23	0.7	348	9.8
2007	12	Unreliable	352	9.8
2008	13	Unreliable	332	9.2
2009	28	0.7	413	11.2
2010	23	0.6	396	10.7
2011	28	0.7	399	10.6
2012	22	0.6	430	11.3
2013	27	0.7	421	10.9
2014	49	1.2	443	11.3
2015	26	0.6	477	12.1

Unreliable = Rate is considered unreliable if the numerator is less than 20.

[73] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Table 58. Suicide Mortality in the Middle Years, Texas 2000-2017[74]

Year	25-34 years Number	25-34 years Rate	35-44 years Number	35-44 years Rate	45-54 years Number	45-54 years Rate	55-64 years Number	55-64 years Rate
2000	367	11.6	437	13.2	390	14.9	184	11.5
2001	383	12.0	484	14.5	428	15.5	224	13.4
2002	403	12.5	529	15.9	435	15.4	243	13.7
2003	372	11.5	506	15.2	527	18.1	251	13.4
2004	397	12.2	455	13.7	450	15.1	273	13.8
2005	414	12.6	487	14.6	500	16.2	283	13.6
2006	405	12.0	463	13.7	473	14.9	315	14.3
2007	424	12.4	471	13.8	524	16.0	329	14.3
2008	445	12.7	473	13.8	566	17.0	344	14.3
2009	452	12.7	505	14.7	638	18.8	390	15.5
2010	475	13.1	516	14.9	618	18.0	441	17.0
2011	478	12.9	519	14.9	597	17.3	450	16.5
2012	514	13.7	518	14.7	608	17.6	465	16.6
2013	549	14.3	491	13.7	592	17.2	498	17.3
2014	581	14.8	526	14.5	648	18.7	487	16.4

[74] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Year	25-34 years Number	25-34 years Rate	35-44 years Number	35-44 years Rate	45-54 years Number	45-54 years Rate	55-64 years Number	55-64 years Rate
2015	612	15.3	582	15.8	659	18.8	544	17.8
2016	666	16.3	565	15.2	626	17.8	529	17.0
2017	711	17.1	617	16.2	631	17.8	589	18.5

Table 59. Suicide Mortality in Older Texas Residents, 2000-2017[75]

Year	65-74 years Number	65-74 years Rate	75-84 years Number	75-84 years Rate	85+ years Number	85+ years Rate
2000	134	11.7	116	16.8	48	20.2
2001	156	13.5	140	19.7	51	21.4
2002	165	14.1	146	20.1	37	15.5
2003	157	13.2	132	17.8	40	16.5
2004	163	13.5	160	21.2	40	16.3
2005	157	12.8	128	16.6	52	20.3
2006	141	11.1	130	16.5	46	17.3
2007	149	11.3	115	14.4	56	20.3
2008	185	13.5	137	17.0	52	18.2
2009	200	14.0	121	14.9	57	19.2
2010	202	13.7	146	17.7	67	22.0
2011	226	14.7	130	15.4	60	18.6
2012	238	14.5	170	19.8	64	19.1
2013	254	14.6	143	16.2	79	22.7
2014	281	15.3	159	17.6	74	20.5
2015	264	13.7	143	15.4	92	24.6
2016	274	13.6	176	18.4	72	18.6
2017	314	15.0	173	17.5	76	19.2

[75] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Race and Ethnicity

Table 60. Texas Suicide Mortality by Race and Ethnicity, 2000-2017[76]

Year	Asian or Pacific Islander Number	Asian or Pacific Islander Rate	Black or African American Number	Black or African American Rate	Hispanic or Latino Number	Hispanic or Latino Rate	White Number	White Rate
2000	24	4.0	134	5.6	347	5.4	1,534	13.8
2001	33	5.1	137	5.6	334	4.9	1,707	15.3
2002	26	3.8	134	5.3	370	5.3	1,768	15.8
2003	44	6.1	123	4.8	389	5.4	1,792	16.0
2004	30	3.9	136	5.3	394	5.3	1,724	15.4
2005	31	3.9	154	5.9	432	5.6	1,783	15.8
2006	39	4.6	125	4.5	411	5.1	1,738	15.3
2007	47	5.2	116	4.1	422	5.1	1,827	16.0
2008	32	3.4	110	3.8	391	4.6	1,995	17.4
2009	51	5.2	143	4.9	496	5.6	2,072	17.9
2010	47	4.6	169	5.7	521	5.8	2,129	18.4
2011	56	5.3	158	5.2	477	5.1	2,178	18.6
2012	66	5.9	174	5.6	551	5.8	2,225	18.9
2013	71	6.0	178	5.6	540	5.6	2,245	19.0
2014	65	5.2	225	6.9	599	6.0	2,332	19.5
2015	81	6.1	190	5.7	613	6.0	2,483	20.6
2016	87	6.3	235	6.9	696	6.7	2,437	20.1
2017	102	7.0	271	7.8	778	7.3	2,589	21.4

[76] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Sex

Table 61. Texas Suicide Mortality by Sex, 2000-2017[77]

Year	Male Number	Male Rate	Female Number	Female Rate	Total Number	Total Rate
2000	1,644	15.9	404	3.8	2,048	9.8
2001	1,779	16.8	442	4.1	2,221	10.4
2002	1,804	16.7	503	4.6	2,307	10.6
2003	1,851	16.9	507	4.6	2,358	10.7
2004	1,797	16.2	496	4.4	2,293	10.2
2005	1,918	17.0	492	4.3	2,410	10.6
2006	1,844	15.9	500	4.2	2,344	10.0
2007	1,931	16.3	501	4.2	2,432	10.2
2008	2,049	17.0	498	4.1	2,547	10.5
2009	2,234	18.2	572	4.6	2,806	11.3
2010	2,297	18.4	589	4.6	2,886	11.5
2011	2,290	18.0	597	4.6	2,887	11.2
2012	2,413	18.6	616	4.7	3,029	11.6
2013	2,385	18.1	669	5.0	3,054	11.5
2014	2,523	18.9	725	5.3	3,248	12.0
2015	2,613	19.2	787	5.7	3,400	12.4
2016	2,711	19.6	766	5.5	3,477	12.5
2017	2,954	21.0	815	5.7	3,769	13.3

[77] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Table 62. Male Suicide Mortality by Race and Ethnicity, Texas 2000-2017[78]

Year	White Male Number	White Male Rate	Hispanic Male Number	Hispanic Male Rate	Black or African American Male Number	Black or African American Male Rate	Asian / Pacific Islander Male Number	Asian / Pacific Islander Male Rate
2000	1,211	22.2	306	9.3	107	9.2	14	Unreliable
2001	1,349	24.6	286	8.3	111	9.3	24	7.5
2002	1,358	24.7	316	8.8	106	8.8	18	Unreliable
2003	1,391	25.3	329	8.9	92	7.5	32	9.0
2004	1,325	24.0	330	8.7	117	9.4	17	Unreliable
2005	1,384	25.0	380	9.7	123	9.7	23	5.9
2006	1,346	24.0	342	8.5	106	8.0	27	6.5
2007	1,423	25.3	360	8.6	100	7.4	32	7.3
2008	1,584	27.9	340	7.9	92	6.7	20	4.3
2009	1,634	28.6	425	9.5	115	8.2	28	5.8
2010	1,685	29.4	422	9.3	142	9.9	31	6.2
2011	1,714	29.7	394	8.4	130	8.9	38	7.3
2012	1,752	30.1	462	9.7	144	9.6	44	8.1
2013	1,749	29.8	437	9.0	142	9.3	44	7.7
2014	1,790	30.3	483	9.7	183	11.6	47	7.7
2015	1,889	31.7	490	9.6	159	9.9	52	8.0
2016	1,880	31.4	561	10.8	187	11.4	67	9.9
2017	2,024	33.7	626	11.7	205	12.2	79	11.1

Unreliable = Rate is considered unreliable if the numerator is less than 20.

[78] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Table 63. Texas Female Suicide Mortality by Race and Ethnicity, 2000-2017[79]

Year	White Female Number	White Female Rate	Hispanic Female Number	Hispanic Female Rate	Black or African American Female Number	Black or African American Female Rate	Asian / Pacific Islander Female Number	Asian / Pacific Islander Female Rate
2000	323	5.7	41	1.3	27	2.2	10	Unreliable
2001	358	6.3	48	1.4	26	2.0	*	*
2002	410	7.2	54	1.6	28	2.2	*	*
2003	401	7.1	60	1.7	31	2.4	12	Unreliable
2004	399	7.0	64	1.7	19	Unreliable	13	Unreliable
2005	399	7.0	52	1.4	31	2.3	*	*
2006	392	6.8	69	1.7	19	Unreliable	12	Unreliable
2007	404	7.0	62	1.5	16	Unreliable	15	Unreliable
2008	411	7.1	51	1.2	18	Unreliable	12	Unreliable
2009	438	7.5	71	1.6	28	1.8	23	4.5
2010	444	7.6	99	2.2	27	1.8	16	Unreliable
2011	464	7.8	83	1.8	28	1.8	18	Unreliable
2012	473	8.0	89	1.9	30	1.9	22	3.8
2013	496	8.3	103	2.2	36	2.2	27	4.5
2014	542	9.0	116	2.4	42	2.5	18	Unreliable
2015	594	9.8	123	2.4	31	1.8	29	4.2
2016	557	9.1	135	2.6	48	2.7	20	2.8
2017	565	9.2	152	2.9	66	3.7	23	3.1

Unreliable = Rate is considered unreliable if the numerator is less than 20.

*= Less than 10

[79] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

Veterans

Table 64. Age-Adjusted Suicide Mortality by Veteran Status, 2005-2017[80]

Year	State of Death	Veteran Suicides	Veteran Suicide Rate per 100,000	General Population Suicides	General Population Rate per 100,000
2005	Texas	403	23.8	2,323	14.6
2006	Texas	378	22.5	2,269	13.4
2007	Texas	386	23.2	2,357	13.7
2008	Texas	435	26.0	2,476	14.2
2009	Texas	447	27.0	2,710	15.2
2010	Texas	474	28.5	2,816	15.4
2011	Texas	473	28.5	2,789	15.0
2012	Texas	471	28.6	2,943	15.5
2013	Texas	466	28.8	2,942	15.2
2014	Texas	469	29.0	3,127	15.8
2015	Texas	518	32.3	3,290	16.3
2016	Texas	530	33.2	3,339	16.3
2017	Texas	496	31.3	3,582	17.2

[80] US Veteran's Administration

Public Health Region

Table 65. Suicide Mortality by Public Health Region (PHR) of Residence with Rates Higher than the State Rate, Texas 2000-2016[81]

Year	PHR 1 Rate	PHR 1 Deaths	PHR 2 Rate	PHR 2 Deaths	PHR 4 Rate	PHR 4 Deaths	PHR 5 Rate	PHR 5 Deaths	Total Rate	Total Deaths
2000	11.9	93	12.2	67	13.5	137	14.0	104	10.0	2,093
2001	14.0	110	10.2	56	14.7	151	11.0	82	10.4	2,214
2002	13.6	107	10.4	57	14.8	154	11.5	86	10.6	2,304
2003	12.1	96	13.2	72	18.9	197	14.3	107	10.6	2,355
2004	10.9	86	13.2	72	15.2	160	13.2	99	10.2	2,290
2005	12.7	101	14.5	79	15.3	162	11.7	88	10.5	2,400
2006	11.4	91	12.1	66	13.6	146	15.7	118	9.9	2,332
2007	12.2	99	13.2	72	12.8	139	13.6	102	10.3	2,470
2008	13.0	106	15.0	82	15.5	169	14.9	112	10.8	2,618
2009	13.7	113	15.4	85	17.3	190	15.3	116	11.3	2,795
2010	15.5	130	19.1	105	17.8	198	18.2	140	11.5	2,903
2011	14.3	122	15.2	84	17.7	199	13.3	103	10.9	2,802
2012	14.3	123	15.4	86	20.0	226	12.9	100	11.6	3,032
2013	13.6	117	17.3	96	14.8	168	14.1	110	11.5	3,047

[81] Center for Health Statistics, Department of State Health Services

Year	PHR 1 Rate	PHR 1 Deaths	PHR 2 Rate	PHR 2 Deaths	PHR 4 Rate	PHR 4 Deaths	PHR 5 Rate	PHR 5 Deaths	Total Rate	Total Deaths
2014	16.0	139	20.8	116	16.6	189	17.0	132	12.0	3,225
2015	17.0	148	14.9	83	18.3	210	16.5	128	12.3	3,368
2016	17.2	151	19.8	110	17.9	206	14.4	112	12.5	3,488
Total	13.8	1,932	14.8	1,388	16.2	3,001	14.2	1,839	11.1	45,736

Table 66. Suicide Mortality by Public Health Region (PHR) of Residence with Rates Lower than the State Rate, Texas 2000-2016[82]

Year	PHR 3 Rate	PHR 3 Deaths	PHR 6 Rate	PHR 6 Deaths	PHR 10 Rate	PHR 10 Deaths	PHR 11 Rate	PHR 11 Deaths	Total Rate	Total Deaths
2000	8.9	491	10.0	486	8.5	60	6.6	114	10.0	2,093
2001	10.2	576	10.6	527	6.2	44	6.1	109	10.4	2,214
2002	9.6	558	11.5	585	7.9	57	7.1	129	10.6	2,304
2003	9.9	589	10.7	554	6.5	48	6.8	127	10.6	2,355
2004	9.7	587	10.4	550	7.8	58	6.6	126	10.2	2,290
2005	10.6	654	9.6	522	6.6	50	6.5	127	10.5	2,400
2006	9.3	593	9.3	521	7.8	60	6.3	125	9.9	2,332
2007	9.8	639	10.1	580	7.9	61	7.4	148	10.3	2,470
2008	10.1	672	10.6	623	8.1	63	7.6	153	10.8	2,618
2009	10.2	689	11.3	677	8.4	66	6.6	134	11.3	2,795
2010	10.9	733	10.6	643	6.4	53	7.9	166	11.5	2,903
2011	10.4	718	10.8	672	5.8	49	6.2	134	10.9	2,802
2012	11.2	783	10.2	649	7.6	65	8.2	178	11.6	3,032
2013	11.4	809	10.6	685	9.2	79	8.2	181	11.5	3,047
2014	11.1	802	10.5	702	11.1	95	7.8	174	12.0	3,225
2015	11.7	862	11.8	802	8.2	71	8.7	194	12.3	3,368

[82] Center for Health Statistics, Department of State Health Services

Year	PHR 3 Rate	PHR 3 Deaths	PHR 6 Rate	PHR 6 Deaths	PHR 10 Rate	PHR 10 Deaths	PHR 11 Rate	PHR 11 Deaths	Total Rate	Total Deaths
2016	12.1	917	11.4	789	10.7	93	8.9	200	12.5	3,488
Total	10.5	11,672	10.6	10,567	8.0	1,072	7.3	2,519	11.1	45,736

Table 67. Suicide Mortality by Public Health Region (PHR) of Residence with Rates Around the State Rate, Texas 2000-2016[83]

Year	PHR 7 Rate	PHR 7 Deaths	PHR 8 Rate	PHR 8 Deaths	PHR 9 Rate	PHR 9 Deaths	Total Rate	Total Deaths
2000	10.7	247	10.9	234	11.4	60	10.0	2,093
2001	11.2	268	10.5	229	11.9	62	10.4	2,214
2002	12.0	290	9.7	216	12.4	65	10.6	2,304
2003	10.5	259	10.4	235	13.5	71	10.6	2,355
2004	10.8	271	9.4	215	12.5	66	10.2	2,290
2005	11.6	299	10.8	252	12.6	66	10.5	2,400
2006	10.7	285	11.5	275	9.7	52	9.9	2,332
2007	11.5	313	10.4	254	11.7	63	10.3	2,470
2008	11.3	317	10.7	266	10.1	55	10.8	2,618
2009	11.6	335	12.2	308	14.8	82	11.3	2,795
2010	12.2	359	12.1	316	10.5	60	11.5	2,903
2011	11.6	351	10.9	291	13.6	79	10.9	2,802
2012	12.7	390	12.5	340	15.5	92	11.6	3,032
2013	12.7	399	11.2	307	15.7	96	11.5	3,047
2014	13.8	443	12.4	347	13.8	86	12.0	3,225
2015	13.4	442	11.6	331	15.2	97	12.3	3,368

[83] Data Source: Center for Health Statistics, Department of State Health Services

Year	PHR 7 Rate	PHR 7 Deaths	PHR 8 Rate	PHR 8 Deaths	PHR 9 Rate	PHR 9 Deaths	Total Rate	Total Deaths
2016	13.2	443	13.2	383	13.2	84	12.5	3,488
Total	11.9	5,711	11.3	4,799	12.9	1,236	11.1	45,736

Metro and Non-metro

Table 68. Texas Suicide Mortality in Metro and Non-Metro Areas, 2000-2017[84]

Year	Metro Number	Metro Rate	Non-metro Number	Non-metro Rate
2000	1,701	9.4	352	12.3
2001	1,873	10.2	352	12.3
2002	1,943	10.3	368	12.8
2003	1,957	10.2	406	14.0
2004	1,891	9.7	409	14.1
2005	2,042	10.3	376	12.9
2006	1,993	9.8	354	12.0
2007	2,065	9.9	368	12.5
2008	2,177	10.2	375	12.6
2009	2,370	10.9	439	14.7
2010	2,383	10.8	508	16.9
2011	2,450	10.8	446	14.8
2012	2,579	11.2	458	15.2
2013	2,600	11.1	459	15.2
2014	2,748	11.5	506	16.7
2015	2,881	11.8	522	17.2
2016	2,998	12.1	490	16.1
2017	3,238	12.8	540	17.6

[84] National Center for Health Statistics, Centers for Disease Control and Prevention, WISQARS

County

Table 69. Suicide Mortality by County of Residence, Texas 2000-2017[85]

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Anderson County, TX	217	1,028,503	21.1
Andrews County, TX	40	267,499	15
Angelina County, TX	203	1,527,736	13.3
Aransas County, TX	96	426,275	22.5
Archer County, TX	18	160,370	11.2 (Unreliable)
Armstrong County, TX	*	35,524	*
Atascosa County, TX	112	798,389	14
Austin County, TX	92	493,683	18.6
Bailey County, TX	14	125,618	11.1 (Unreliable)
Bandera County, TX	71	361,370	19.6
Bastrop County, TX	210	1,296,535	16.2
Baylor County, TX	*	68,133	*
Bee County, TX	86	580,854	14.8
Bell County, TX	674	5,297,103	12.7
Bexar County, TX	3,144	30,000,117	10.5
Blanco County, TX	36	181,337	19.9
Borden County, TX	*	11,653	*
Bosque County, TX	58	322,182	18
Bowie County, TX	258	1,644,994	15.7
Brazoria County, TX	677	5,426,303	12.5
Brazos County, TX	259	3,361,683	7.7
Brewster County, TX	30	163,139	18.4

[85] Center for Health Statistics, Department of State Health Services and National Center for Health Statistics, Centers for Disease Control and Prevention WONDER

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Briscoe County, TX	*	29,622	^
Brooks County, TX	21	133,356	15.7
Brown County, TX	109	683,393	15.9
Burleson County, TX	52	308,263	16.9
Burnet County, TX	105	748,092	14
Caldwell County, TX	81	675,725	12
Calhoun County, TX	46	381,822	12
Callahan County, TX	45	240,443	18.7
Cameron County, TX	427	7,027,371	6.1
Camp County, TX	31	219,495	14.1
Carson County, TX	23	112,563	20.4
Cass County, TX	90	543,861	16.5
Castro County, TX	13	142,867	9.1 (Unreliable)
Chambers County, TX	76	595,037	12.8
Cherokee County, TX	147	895,375	16.4
Childress County, TX	19	129,589	14.7 (Unreliable)
Clay County, TX	31	195,002	15.9
Cochran County, TX	14	57,682	24.3 (Unreliable)
Coke County, TX	13	61,836	21.0 (Unreliable)
Coleman County, TX	21	157,545	13.3
Collin County, TX	1,253	13,342,128	9.4
Collingsworth County, TX	10	54,751	18.3 (Unreliable)
Colorado County, TX	49	372,129	13.2
Comal County, TX	292	1,892,059	15.4
Comanche County, TX	27	246,861	10.9
Concho County, TX	*	71,401	*
Cooke County, TX	120	688,421	17.4

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Coryell County, TX	193	1,338,862	14.4
Cottle County, TX	*	28,133	^
Crane County, TX	13	77,314	16.8 (Unreliable)
Crockett County, TX	*	68,127	*
Crosby County, TX	10	113,755	8.8 (Unreliable)
Culberson County, TX	*	45,066	*
Dallam County, TX	17	118,945	14.3 (Unreliable)
Dallas County, TX	4,203	42,671,128	9.8
Dawson County, TX	24	250,032	9.6
Deaf Smith County, TX	33	340,394	9.7
Delta County, TX	11	94,985	11.6 (Unreliable)
Denton County, TX	1,103	11,412,349	9.7
DeWitt County, TX	50	364,557	13.7
Dickens County, TX	*	43,995	*
Dimmit County, TX	20	184,641	10.8
Donley County, TX	*	66,277	*
Duval County, TX	31	216,879	14.3
Eastland County, TX	46	331,030	13.9
Ector County, TX	306	2,463,166	12.4
Edwards County, TX	*	35,978	*
Ellis County, TX	268	2,568,117	10.4
El Paso County, TX	1,111	13,897,201	8
Erath County, TX	85	671,815	12.7
Falls County, TX	42	319,959	13.1
Fannin County, TX	121	598,947	20.2
Fayette County, TX	58	431,740	13.4
Fisher County, TX	*	72,524	*

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Floyd County, TX	11	119,622	9.2 (Unreliable)
Foard County, TX	*	24,839	*
Fort Bend County, TX	795	9,949,992	8
Franklin County, TX	26	186,428	13.9
Freestone County, TX	64	345,236	18.5
Frio County, TX	23	312,480	7.4
Gaines County, TX	33	307,580	10.7
Galveston County, TX	751	5,208,845	14.4
Garza County, TX	*	108,748	<
Gillespie County, TX	73	432,142	16.9
Glasscock County, TX	*	23,054	*
Goliad County, TX	25	130,287	19.2
Gonzales County, TX	48	355,614	13.5
Gray County, TX	77	404,667	19
Grayson County, TX	360	2,150,617	16.7
Gregg County, TX	318	2,140,345	14.9
Grimes County, TX	66	470,032	14
Guadalupe County, TX	260	2,227,057	11.7
Hale County, TX	57	642,181	8.9
Hall County, TX	*	61,737	*
Hamilton County, TX	29	149,691	19.4
Hansford County, TX	10	97,689	10.2 (Unreliable)
Hardeman County, TX	*	76,364	<
Hardin County, TX	152	953,199	15.9
Harris County, TX	7,217	72,037,135	10
Harrison County, TX	172	1,164,032	14.8
Hartley County, TX	*	105,630	*

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Haskell County, TX	26	105,597	24.6
Hays County, TX	314	2,712,863	11.6
Hemphill County, TX	*	67,442	*
Henderson County, TX	270	1,401,681	19.3
Hidalgo County, TX	675	13,215,072	5.1
Hill County, TX	108	620,416	17.4
Hockley County, TX	58	414,693	14
Hood County, TX	141	893,248	15.8
Hopkins County, TX	82	619,588	13.2
Houston County, TX	62	419,054	14.8
Howard County, TX	106	625,175	17
Hudspeth County, TX	*	62,576	*
Hunt County, TX	245	1,530,031	16
Hutchinson County, TX	60	400,445	15
Irion County, TX	*	29,076	*
Jack County, TX	20	161,134	12.4
Jackson County, TX	38	256,935	14.8
Jasper County, TX	95	639,925	14.8
Jeff Davis County, TX	*	40,581	*
Jefferson County, TX	550	4,525,124	12.2
Jim Hogg County, TX	12	93,821	12.8 (Unreliable)
Jim Wells County, TX	95	732,214	13
Johnson County, TX	351	2,653,473	13.2
Jones County, TX	85	362,903	23.4
Karnes County, TX	37	271,122	13.6
Kaufman County, TX	250	1,756,450	14.2
Kendall County, TX	91	585,158	15.6

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Kenedy County, TX	*	7,567	^
Kent County, TX	*	14,350	^
Kerr County, TX	183	869,378	21
Kimble County, TX	17	81,342	20.9 (Unreliable)
King County, TX	*	5,244	^
Kinney County, TX	*	63,435	*
Kleberg County, TX	44	569,378	7.7
Knox County, TX	*	69,220	*
Lamar County, TX	152	888,868	17.1
Lamb County, TX	30	253,581	11.8
Lampasas County, TX	57	352,455	16.2
La Salle County, TX	10	122,246	8.2 (Unreliable)
Lavaca County, TX	42	348,653	12
Lee County, TX	34	296,849	11.5
Leon County, TX	55	296,410	18.6
Liberty County, TX	192	1,364,635	14.1
Limestone County, TX	66	415,467	15.9
Lipscomb County, TX	*	58,603	*
Live Oak County, TX	33	212,458	15.5
Llano County, TX	68	340,748	20
Loving County, TX	0	1,484	0
Lubbock County, TX	637	4,914,526	13
Lynn County, TX	15	108,411	13.8 (Unreliable)
McCulloch County, TX	27	147,221	18.3
McLennan County, TX	451	4,161,950	10.8
McMullen County, TX	*	13,857	^
Madison County, TX	37	243,132	15.2

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Marion County, TX	43	191,646	22.4
Martin County, TX	*	88,212	<
Mason County, TX	12	70,772	17.0 (Unreliable)
Matagorda County, TX	82	666,086	12.3
Maverick County, TX	50	951,721	5.3
Medina County, TX	87	808,399	10.8
Menard County, TX	*	40,080	^
Midland County, TX	286	2,455,684	11.6
Milam County, TX	63	445,164	14.2
Mills County, TX	*	88,424	<
Mitchell County, TX	24	166,862	14.4
Montague County, TX	77	351,247	21.9
Montgomery County, TX	1,119	7,778,192	14.4
Moore County, TX	33	381,932	8.6
Morris County, TX	43	232,718	18.5
Motley County, TX	*	22,313	*
Nacogdoches County, TX	134	1,134,046	11.8
Navarro County, TX	138	851,265	16.2
Newton County, TX	43	260,004	16.5
Nolan County, TX	40	271,525	14.7
Nueces County, TX	693	6,061,777	11.4
Ochiltree County, TX	32	178,487	17.9
Oldham County, TX	*	37,170	*
Orange County, TX	244	1,499,622	16.3
Palo Pinto County, TX	101	499,489	20.2
Panola County, TX	53	421,571	12.6
Parker County, TX	303	2,004,550	15.1

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Parmer County, TX	12	180,522	6.6 (Unreliable)
Pecos County, TX	27	283,529	9.5
Polk County, TX	163	818,838	19.9
Potter County, TX	368	2,148,048	17.1
Presidio County, TX	10	134,007	7.5 (Unreliable)
Rains County, TX	35	193,165	18.1
Randall County, TX	355	2,128,070	16.7
Reagan County, TX	*	61,013	*
Real County, TX	10	58,539	17.1 (Unreliable)
Red River County, TX	47	235,245	20
Reeves County, TX	26	244,615	10.6
Refugio County, TX	12	134,228	8.9 (Unreliable)
Roberts County, TX	*	15,847	^
Robertson County, TX	43	296,800	14.5
Rockwall County, TX	157	1,294,958	12.1
Runnels County, TX	22	191,469	11.5
Rusk County, TX	141	924,838	15.2
Sabine County, TX	36	189,066	19
San Augustine County, TX	27	159,105	17
San Jacinto County, TX	82	462,929	17.7
San Patricio County, TX	152	1,197,632	12.7
San Saba County, TX	13	107,972	12.0 (Unreliable)
Schleicher County, TX	*	56,526	*
Scurry County, TX	35	299,856	11.7
Shackelford County, TX	*	60,032	*
Shelby County, TX	66	458,166	14.4
Sherman County, TX	11	55,108	20.0 (Unreliable)

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Smith County, TX	553	3,651,807	15.1
Somervell County, TX	31	145,333	21.3
Starr County, TX	75	1,076,461	7
Stephens County, TX	38	170,817	22.2
Sterling County, TX	*	22,473	*
Stonewall County, TX	*	26,256	*
Sutton County, TX	10	73,355	13.6 (Unreliable)
Swisher County, TX	22	141,315	15.6
Tarrant County, TX	3,361	31,554,991	10.7
Taylor County, TX	342	2,349,248	14.6
Terrell County, TX	*	16,754	*
Terry County, TX	30	226,766	13.2
Throckmorton County, TX	*	29,779	*
Titus County, TX	80	555,099	14.4
Tom Green County, TX	280	1,976,739	14.2
Travis County, TX	2,135	18,049,047	11.8
Trinity County, TX	39	257,795	15.1
Tyler County, TX	78	382,747	20.4
Upshur County, TX	133	696,785	19.1
Upton County, TX	*	60,047	*
Uvalde County, TX	48	477,349	10.1
Val Verde County, TX	66	858,511	7.7
Van Zandt County, TX	189	935,694	20.2
Victoria County, TX	234	1,570,832	14.9
Walker County, TX	185	1,201,226	15.4
Waller County, TX	101	746,315	13.5
Ward County, TX	25	194,176	12.9

County	Total Number	Total Population (2000-2017 combined)	Total Rate
Washington County, TX	58	591,594	9.8
Webb County, TX	235	4,313,756	5.4
Wharton County, TX	81	741,360	10.9
Wheeler County, TX	19	95,647	19.9 (Unreliable)
Wichita County, TX	369	2,362,965	15.6
Wilbarger County, TX	37	244,601	15.1
Willacy County, TX	21	384,782	5.5
Williamson County, TX	736	7,167,279	10.3
Wilson County, TX	93	741,355	12.5
Winkler County, TX	24	129,326	18.6
Wise County, TX	132	1,042,591	12.7
Wood County, TX	137	739,415	18.5
Yoakum County, TX	13	140,530	9.3 (Unreliable)
Young County, TX	59	326,278	18.1
Zapata County, TX	13	243,633	5.3 (Unreliable)
Zavala County, TX	18	212,086	8.5 (Unreliable)
All of Texas	**49,516**	**441,288,109**	**11.2**

*= Less than 10

^= Above the state rate

<= Below the state rate

Hospitalizations

Table 70. Hospitalizations for Attempted Suicide by Year, 2000-2018[86]

Year	Total	Rate per 100,000
2000	12,530	59.8
2001	10,060	47.2
2002	10,522	48.5
2003	10,464	47.5
2004	10,857	48.5
2005	11,280	49.5
2006	11,875	50.8
2007	12,304	51.6
2008	11,996	49.3
2009	11,967	48.3
2010	12,951	51.5
2011	13,086	51.0
2012	13,056	50.1
2013	13,088	49.5
2014	12,678	47.0
2015	13,102	47.7
2016	13,434	48.2
2017	14,165	50.0
2018	15,443	53.8

[86] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Public Health Region

Table 71. Hospitalizations for Suicide Attempts by Public Health Region (PHR) 1-4, Texas 2000-2018[87]

Year	PHR 1 Number	PHR 1 Rate	PHR 2 Number	PHR 2 Rate	PHR 3 Number	PHR 3 Rate	PHR 4 Number	PHR 4 Rate
2000	810	103.7	197	35.9	2,612	47.6	873	86.0
2001	485	61.9	206	37.6	1,992	35.1	533	51.9
2002	570	72.4	229	41.8	2,468	42.4	584	56.2
2003	430	54.3	193	35.3	2,530	42.7	567	54.3
2004	453	57.2	160	29.3	2,776	45.9	612	58.0
2005	530	66.8	168	30.8	3,026	49.1	578	54.5
2006	606	75.7	213	38.9	3,215	50.6	637	59.1
2007	678	83.7	214	39.1	3,079	47.4	729	67.4
2008	632	77.5	227	41.5	2,987	45.1	703	64.7
2009	623	75.5	228	41.3	2,970	43.9	536	48.9
2010	759	90.4	268	48.7	3,524	52.3	538	48.4
2011	755	88.7	262	47.5	3,427	49.8	595	53.0
2012	727	84.5	200	35.9	3,201	45.9	521	46.0
2013	754	87.3	206	37.0	3,080	43.4	487	43.0
2014	659	74.9	305	54.2	2,934	40.2	481	41.4
2015	702	78.9	344	60.8	3,026	40.7	529	45.1
2016	748	83.2	282	49.6	3,818	50.3	586	49.4
2017	871	95.7	291	50.9	3,873	49.9	587	49.0
2018	401	43.6	234	40.8	3,487	44.0	535	44.2

[87] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Table 72. Hospitalizations for Suicide Attempts by Public Health Region (PHR) 5-8, Texas 2000-2018[88]

Year	PHR 5 Number	PHR 5 Rate	PHR 6 Number	PHR 6 Rate	PHR 7 Number	PHR 7 Rate	PHR 8 Number	PHR 8 Rate
2000	548	74.0	2,112	43.5	2,137	92.5	1,002	46.7
2001	395	53.0	2,491	50.1	961	40.3	1,194	54.7
2002	428	57.2	2,298	45.0	844	34.8	1,412	63.5
2003	412	55.1	2,380	45.8	869	35.1	1,353	59.9
2004	407	54.1	2,276	42.8	1,001	39.8	1,493	65.0
2005	409	54.6	2,470	45.6	1,063	41.2	1,462	62.7
2006	402	53.6	2,431	43.2	1,153	43.3	1,523	63.7
2007	464	61.7	2,614	45.5	1,196	43.9	1,595	65.5
2008	347	46.0	2,364	40.3	1,251	44.4	1,698	68.4
2009	341	44.9	2,521	42.1	1,246	43.3	1,623	64.2
2010	383	49.9	2,481	40.8	1,351	45.8	1,676	64.3
2011	307	39.7	2,541	40.8	1,359	45.0	1,720	64.5
2012	309	39.7	2,480	39.2	1,444	47.0	1,901	70.2
2013	261	33.5	2,541	39.3	1,408	44.9	1,692	61.6
2014	244	30.7	2,443	36.8	1,256	38.7	1,552	55.2
2015	280	34.9	2,438	35.9	1,447	43.5	1,661	57.9
2016	304	37.6	2,510	36.1	1,494	43.8	1,636	56.0
2017	329	40.4	2,711	38.2	1,622	46.4	1,820	61.1
2018	267	32.5	2,400	33.0	2,089	58.3	1,792	59.1

[88] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Table 73. Hospitalizations for Suicide Attempts by Public Health Region (PHR) 9-11, Texas 2000-2018[89]

Year	PHR 9 Number	PHR 9 Rate	PHR 10 Number	PHR 10 Rate	PHR 11 Number	PHR 11 Rate
2000	401	76.4	277	39.3	1,027	59.1
2001	228	43.6	211	29.6	801	45.0
2002	244	46.4	198	27.3	1,000	54.7
2003	223	42.3	239	32.6	995	53.3
2004	260	49.3	211	28.5	1,007	52.8
2005	231	43.9	166	22.1	968	49.8
2006	234	43.8	178	23.1	1,049	52.6
2007	290	54.1	193	25.0	1,040	51.7
2008	319	58.5	207	26.7	1,032	51.1
2009	234	42.1	253	32.4	1,123	54.9
2010	259	45.3	241	29.2	1,143	54.3
2011	298	51.4	256	30.2	1,253	58.1
2012	231	39.0	267	31.0	1,454	66.7
2013	255	41.7	285	33.3	1,769	80.5
2014	315	52.5	258	29.1	1,837	80.6
2015	307	50.6	327	36.3	1,703	73.3
2016	273	44.5	296	32.3	1,131	47.7
2017	265	42.7	349	37.4	1,096	45.3
2018	269	42.8	308	32.5	1,123	45.6

[89] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Race and Ethnicity

Table 74. Hospitalizations for Suicide Attempt by Race and Ethnicity, Texas 2000-2018[90]

Year	White Number	White Rate	Hispanic Number	Hispanic Rate	Black or African American Number	Black or African American Rate	Other Number	Other Rate
2000	8,583	77.5	3,640	54.6	1,581	65.3	927	135.2
2001	6,315	56.6	2,256	32.3	912	37.0	577	79.2
2002	6,629	59.1	2,396	32.9	869	34.6	628	81.4
2003	6,434	57.4	2,427	32.1	898	35.4	705	87.1
2004	6,704	59.7	2,473	31.5	999	38.9	681	80.0
2005	6,951	61.9	2,549	31.3	1,008	38.8	772	86.5
2006	7,343	64.8	2,646	31.2	1,079	39.2	807	85.5
2007	7,722	68.1	2,765	31.4	1,076	38.7	741	74.7
2008	7,475	65.9	2,753	30.2	1,013	35.9	755	72.3
2009	7,409	65.2	2,757	29.1	1,005	35.1	797	72.7
2010	7,821	68.6	3,190	33.7	1,158	40.1	782	55.8
2011	7,643	66.8	3,230	32.9	1,276	43.3	937	63.6
2012	7,134	61.8	3,514	35.1	1,118	37.4	1,290	85.8

[90] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Year	White Number	White Rate	Hispanic Number	Hispanic Rate	Black or African American Number	Black or African American Rate	Other Number	Other Rate
2013	7,225	63.0	3,736	36.1	1,198	39.4	929	58.0
2014	6,830	58.8	3,723	34.7	1,111	35.7	1,012	60.2
2015	7,051	60.4	3,884	35.0	1,146	36.1	1,021	58.0
2016	7,401	63.1	3,697	32.3	1,404	43.5	932	50.6
2017	7,481	63.5	4,308	36.5	1,366	41.5	1,010	52.5
2018	7,949	67.2	4,839	39.7	1,439	43.0	1,216	60.5

Poison Control Center

Table 75. Suspected Suicide Calls to Poison Control Network, Total and Rate per 100,000 Population, Texas 2004-2018[91]

Year	Total	Rate
2004	17,391	77.7
2005	17,007	74.7
2006	17,192	73.6
2007	17,746	74.5
2008	17,547	72.2
2009	17,310	69.8
2010	17,527	69.7
2011	18,263	71.1
2012	18,544	71.2
2013	18,667	70.6
2014	20,013	74.2
2015	21,177	77.1
2016	22,463	80.6
2017	24,246	85.7
2018	25,233	87.9

[91] Texas Poison Control Network, Department of State Health Services

Age

Table 76. Suspected Suicide Calls to Poison Control Network by Youth and Young Adult Age Group, Total and Rate per 100,000 Population, Texas 2004-2018[92]

Year	Age Group 6-12 Number	Age Group 6-12 Rate	Age Group 13-19 Number	Age Group 13-19 Rate	Age Group 20-29 Number	Age Group 20-29 Rate
2004	133	5.7	4,382	180.2	4,325	127.6
2005	151	6.5	4,039	163.8	4,282	124.0
2006	151	6.5	4,078	161.4	4,388	123.1
2007	117	5.0	4,180	163.8	4,643	127.7
2008	114	4.8	4,121	160.4	4,519	121.5
2009	123	5.1	4,060	157.2	4,448	117.0
2010	149	5.6	3,989	151.9	4,479	122.0
2011	139	5.1	4,132	154.5	4,709	126.8
2012	209	7.6	4,535	165.8	4,590	123.5
2013	242	8.8	5,069	184.5	4,386	115.1
2014	340	12.1	5,916	209.2	4,385	111.7
2015	330	11.6	6,446	223.1	4,740	118.8
2016	344	12.1	7,054	239.0	5,188	127.7
2017	445	15.6	7,737	256.9	5,668	136.8
2018	538	18.7	8,213	267.5	5,814	137.4

[92] Texas Poison Control Network, Department of State Health Services

Table 77. Suspected Suicide Calls to Poison Control Network by Middle Years Age Group, Total and Rate per 100,000 Population, Texas 2004-2018[93]

Year	Age Group 30-39 Number	Age Group 30-39 Rate	Age Group 40-49 Number	Age Group 40-49 Rate	Age Group 50-59 Number	Age Group 50-59 Rate
2004	3,206	95.6	2,511	75.2	943.0	37.8
2005	3,124	92.3	2,523	74.9	1,000	38.4
2006	3,066	88.3	2,614	76.4	1,087	39.7
2007	3,183	90.1	2,579	75.3	1,209	43.0
2008	3,120	86.8	2,667	77.8	1,370	47.4
2009	3,153	86.2	2,625	76.1	1,248	42.0
2010	3,136	89.0	2,659	77.0	1,448	46.7
2011	3,544	99.2	2,676	76.7	1,540	48.0
2012	3,322	92.2	2,820	80.3	1,698	51.7
2013	3,375	91.7	2,641	75.2	1,651	49.5
2014	3,418	90.1	2,701	75.6	1,798	52.5
2015	3,567	92.2	2,691	74.6	1,868	53.7
2016	3,627	91.8	2,774	75.8	1,915	54.6
2017	3,899	96.7	2,821	75.9	2,095	59.5
2018	4,034	98.2	2,917	77.2	2,036	57.6

[93] Texas Poison Control Network, Department of State Health Services

Table 78. Suspected Suicide Calls to Poison Control Network by Older Age Group, Total and Rate per 100,000 Population, Texas 2004-2018[94]

Year	Age Group 60-69 Number	Age Group 60-69 Rate	Age Group 70-79 Number	Age Group 70-79 Rate	Age Group 80+ Number	Age Group 80+ Rate
2004	236	15.9	82	8.3	28	4.9
2005	261	17.0	67	6.7	28	4.8
2006	276	17.2	87	8.6	32	5.4
2007	286	16.8	78	7.6	23	3.8
2008	328	18.3	109	10.5	25	4.1
2009	340	18.0	122	11.6	48	7.6
2010	386	19.0	114	10.4	45	6.9
2011	447	20.8	97	8.5	40	5.9
2012	463	20.6	131	11.1	53	7.6
2013	497	21.3	146	11.8	52	7.3
2014	552	22.7	163	12.6	54	7.6
2015	642	25.2	137	10.1	58	7.9
2016	711	26.6	177	12.6	58	7.7
2017	791	28.6	228	15.2	52	6.8
2018	833	29.2	248	15.5	75	9.5

[94] Texas Poison Control Network, Department of State Health Services

Outpatient Emergency Department Hospitalizations

Table 79. Texas Outpatient Emergency Department Hospitalizations by Year, 2016-2018[95]

Year	Texas Number	Texas Rate
2016	17,574	62.2
2017	18,697	64.9
2018	21,999	74.9

Public Health Region

Table 80. Texas Outpatient Emergency Department Hospitalizations by Public Health Region (PHR) 2016-2018[95]

PHR	2016 Number	2016 Rate	2017 Number	2017 Rate	2018 Number	2018 Rate
PHR 1	562	62.5	648	71.2	675	73.3
PHR 2	630	110.8	640	112.0	687	119.6
PHR 3	4,837	63.7	4,915	63.4	5,239	66.2
PHR 4	845	71.2	1,118	93.3	1,236	102.0
PHR 5	519	64.2	570	69.9	557	67.8
PHR 6	3,331	48.0	3,881	54.6	4,531	62.4
PHR 7	2,487	72.9	2,419	69.2	3,094	86.4
PHR 8	1,917	65.6	1,952	65.5	2,349	77.4
PHR 9	385	62.7	347	55.9	467	74.3
PHR 10	510	55.7	533	57.2	630	66.5
PHR 11	1,239	52.3	1,339	55.4	1,528	62.0

[95] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Race and Ethnicity

Table 81. Texas Outpatient Emergency Department Hospitalizations by Race and Ethnicity, 2016-2018[96]

Race and Ethnicity	2016 Number	2016 Rate	2017 Number	2017 Rate	2018 Number	2018 Rate
White	8,679	74.0	8,561	72.7	10,058	85.0
Hispanic	4,978	43.5	6,048	51.2	7,309	60.0
Black or African American	2,676	82.8	2,644	80.4	2,980	89.0
Other	1,241	67.4	1,444	75.0	1,652	82.2
Texas Total	17,574	62.2	18,697	64.9	21,999	74.9

[96] Texas Health Care Information Center (THCIC), Center for Health Statistics, Department of State Health Services

Behavioral Risk Factor Surveillance System (BRFSS)

Suicidal Ideation

Table 82. Texas Adults who have Seriously Considered Suicide in the Past 12 Months, 3-Year Combined Prevalence, Texas BRFSS 2016-2018[97]

Suicidal Ideation	Percent	95% CI
Texas	3.2	(2.7-3.8)
Male	3.2	(2.5-4.1)
Female	3.2	(2.6-4.0)
18-24	7.1	(5.0-9.9)
25+	2.7	(2.3-3.3)
White, Non-Hispanic	3.1	(2.5-3.8)
Black, Non-Hispanic	3.7	(2.1-6.6)
Hispanic	3.2	(2.4-4.2)
Other	R	(. - .)

Table 83. Texas Adults who have Seriously Considered Suicide in the Past 12 Months by Age Group and Depressive Disorder, 3-Year Combined Prevalence, Texas BRFSS 2016-2018[97]

Age and Group	Percent	95% CI
18-24 Depressive disorder	24.5	(16.0-35.5)
18-24 No depressive disorder	4.2	(2.4-7.1)
25+ Depressive disorder	10.8	(8.7-13.4)
25+ No depressive disorder	1.1	(0.8-1.5)

[97] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Table 84. Texas Adults who have Seriously Considered Suicide in the Past 12 Months by Age Group and Sexual Orientation, 3-Year Combined Prevalence, Texas BRFSS 2016-2018[98]

Age Group and Sexual Orientation	Percent	95% CI
18-24 LGB	21.5	(11.7-36.3)
18-24 Straight	5.4	(3.5-8.2)
25+ LGB	10.2	(5.9-17.0)
25+ Straight	2.5	(2.1-3.1)

Table 85. Texas Adults who have Seriously Considered Suicide in the Past 12 Months by Age Group and Disability Status, 3-Year Combined Prevalence, Texas BRFSS 2016-2018[99]

Age Group and Disability Status	Percent	95% CI
18-24 Has Disability	13.9	(8.9-21.2)
18-24 No Disability	5.4	(3.3-8.7)
25+ Has Disability	6.4	(5.2-8.0)
25+ No Disability	1.2	(0.8-1.7)

[98] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

[99] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Youth Risk Behavior Survey (YRBS)

Suicidal Ideation

Table 86. High School Students Who Seriously Considered Suicide in the Past 12 Months, Texas and the U.S. 2001-2017[100]

Year	Texas Percent	Texas 95% C.I.	U.S. Percent	U.S. 95% C.I.
2001	17.7	(16.4-19.1)	19.0	(17.7-20.5)
2005	15.9	(14.3-17.5)	16.9	(15.9-17.8)
2007	15.2	(14.0-16.3)	14.5	(13.4-15.6)
2009	13.7	(12.2-15.4)	13.8	(13.1-14.6)
2011	15.8	(14.8-17.1)	15.8	(15.1-16.5)
2013	16.7	(15.1-18.4)	17.0	(15.8-18.2)
2017	17.6	(15.4-20.0)	17.2	(16.2-18.3)

Table 87. Texas High School Students Who Seriously Considered Suicide in the Past 12 Months by Sex,2001-2017[101]

Year	Female Percent	Female 95% C.I.	Male Percent	Male 95% C.I.
2001	23.2	(21.4-25.1)	12.5	(11.0-14.2)
2005	21.0	(19.1-23.1)	10.8	(8.6-13.6)
2007	19.6	(17.6-21.8)	10.8	(9.2-12.7)
2009	17.8	(14.8-21.2)	9.8	(8.3-11.7)
2011	19.8	(18.1-21.7)	11.8	(10.2-13.7)
2013	21.1	(18.7-23.7)	12.4	(10.6-14.6)
2017	21.7	(18.6-25.3)	13.3	(10.7-16.4)

[100] Centers for Disease Control and Prevention, 2001-2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs

[101] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

Table 88. Texas High School Students Who Seriously Considered Suicide in the Past 12 Months by Race and Ethnicity, 2001-2017[102]

Year	White Rate	White 95% C.I.	Black or African American Rate	Black or African American 95% C.I.	Hispanic Rate	Hispanic 95% C.I.	Other Rate	Other 95% C.I.
2001	6.7	(5.5-8.0)	8.4	(5.8-12.2)	12.1	(10.6-13.8)	13.5	(8.2-21.2)
2005	7.6	(6.3-9.1)	8.7	(5.7-12.9)	11.3	(9.8-13.4)	14.5	(8.5-23.6)
2007	6.0	(4.7-7.7)	9.7	(7.3-12.8)	11.0	(8.3-14.6)	8.2	(5.1-13.1)
2009	6.2	(5.1-7.4)	6.0	(3.8-9.2)	8.6	(6.5-11.4)	11.9	(7.1-19.1)
2011	7.4	(5.7-9.7)	14.3	(11.4-17.8)	12.0	(10.4-13.9)	10.0	(6.5-15.1)
2013	8.0	(5.9-10.8)	8.7	(5.8-12.9)	11.4	(9.3-14.0)	9.5	(5.7-15.5)
2017	11.3	(7.6-16.3)	18.7	(11.4-29.0)	11.4	(9.9-13.1)	8.2	(5.5-12.1)

[102] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

Suicide Attempt

Table 89. High School Students Who Attempted Suicide in Texas and the U.S., 2001-2017[103]

Year	Texas Percent	Texas 95% C.I.	U.S. Percent	U.S. 95% C.I.
2001	9.0	(7.9-10.2)	8.8	(8.0-9.7)
2005	9.4	(8.3-10.6)	8.4	(7.6-9.3)
2007	8.4	(7.1-9.9)	6.9	(6.3-7.6)
2009	7.4	(6.3-8.7)	6.3	(5.7-7.0)
2011	10.8	(9.7-12.1)	7.8	(7.1-8.5)
2013	10.1	(8.4-12.1)	8.0	(7.2-8.9)
2017	12.3	(10.2-14.6)	7.4	(6.5-8.4)

Table 90. Texas High School Students Who Attempted Suicide in the Past 12 Months by Sex, 2001-2017[104]

Year	Female Percent	Female 95% C.I.	Male Percent	Male 95% C.I.
2001	12.7	(11.1-14.5)	5.3	(4.3-6.4)
2005	12.5	(10.7-14.6)	6.1	(4.7-7.8)
2007	11.8	(10.0-14.0)	4.9	(3.3-7.3)
2009	10.4	(8.3-13.1)	4.1	(3.3-5.7)
2011	12.9	(11.0-15.1)	8.4	(7.0-10.2)
2013	11.6	(9.3-14.4)	8.6	(7.0-10.5)
2017	13.0	(9.5-17.4)	10.9	(8.7-13.5)

[103] Centers for Disease Control and Prevention, 2001-2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs

[104] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

Table 91. Texas High School Students Who Attempted Suicide in the Past 12 Months, YRBS 2001-2017[105]

Years	White Percent	White 95% C.I.	Black or African American Percent	Black or African American 95% C.I.	Hispanic Percent	Hispanic 95% C.I.	Other Percent	Other 95% C.I.
2001	6.7	(5.5-8.0)	8.4	(5.8-12.2)	12.1	(10.6-13.8)	13.5	(8.2-21.2)
2005	7.6	(6.3-9.1)	8.7	(5.7-12.9)	11.3	(9.8-13.4)	14.5	(8.5-23.6)
2007	6.0	(4.7-7.7)	9.7	(7.3-12.8)	11.0	(8.3-14.6)	8.2	(5.1-13.1)
2009	6.2	(5.1-7.4)	6.0	(3.8-9.2)	8.6	(6.5-11.4)	11.9	(7.1-19.1)
2011	7.4	(5.7-9.7)	14.3	(11.4-17.8)	12.0	(10.4-13.9)	10.0	(6.5-15.1)
2013	8.0	(5.9-10.8)	8.7	(5.8-12.9)	11.4	(9.3-14.0)	9.5	(5.7-15.5)
2017	11.3	(7.6-16.3)	18.7	(11.4-29.0)	11.4	(9.9-13.1)	8.2	(5.5-12.1)

Table 92. Texas High School Students Who Attempted Suicide in the Past 12 Months by Self-Identified Sexual Orientation, Texas YRBS 2017[105]

Sexual Orientation	Percent	95% C.I.
Straight	9.6	(7.5-12.1)
Gay/Lesbian	43.8	(31.8-56.6)
Bisexual	23.2	(16.1-32.3)

[105] Centers for Disease Control and Prevention, 2017 Texas Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs

Appendix B. Texas Statutes

Texas Civil Practice & Remedies Code

Assumption of the Risk: Affirmative Defense

Chapter 93, § 93.001

Disregard of Declaration for Mental Health Treatment

Chapter 137, § 137.008

Texas Code of Criminal Procedure

Deaths Requiring an Inquest

Chapter 49, § 49.04

Medical Examiners/Death Investigations

Chapter 49, § 49.25

Texas Education Code

Facilities Standards

Chapter 7, § 7.061

District-Level Planning and Decision-Making

Chapter 11, § 11.252

Educator Preparation

Chapter 21, § 21.044

Continuing Education

Chapter 21, § 21.054

Staff Development

Chapter 21, § 21.451

Transfer of Victims of Bullying

Chapters 25 and 37, § 25.0342 and § 37.0832

Digital Citizenship

Chapter 28, § 28.002

Essential Knowledge and Skills Curriculum

Chapter 28, § 28.002

Health Curriculum

Chapter 28, § 28.002

Local School Health Advisory Council and Health Education Instruction

Chapter 28, § 28.004

School Health Advisory Council and Suicide

Chapter 28, § 28.004

Counselors

Chapter 33, § 33.006

Student Code of Conduct

Chapter 37, § 37.001

Discipline; Law and Order

Chapter 37, § 37.0012, § 37.002, § 37.007 and § 37.009

Discipline; Law and Order, and Occupations Code, Law Enforcement Officers

Chapter 37, Texas Education Code, § 37.0812

Discipline, Law and Order

Chapter 37, § 37.0832

Threat Assessment and Safe and Supportive School Program and Team

Chapter 37, § 37.115

Multihazard Emergency Operations Plan

Chapter 37, §37.108 (f) (6)

Health and Safety; Psychotropic Drugs and Psychiatric Evaluations or Examinations

Chapter 38, § 38.016

Trauma-Informed Care Policy

Chapter 38, § 38.036

School-Based Health Centers - Parental Consent Required

Chapter 38, § 38.053

Identification of Health-Related Concerns

Chapter 38, § 38.057

Collaborative Task Force on Public School Mental Health Services

Chapter 38, § 38.301-38.311

Funding for Suicide Prevention

Chapter 42, § 42.168

Requirements for Higher Education

Chapter 51, § 51.9193-§ 51.9194

Texas Family Code

Consent to Counseling

Chapter 32, § 32.004

Medical Services to Minors in the Conservatorship of the State

Chapter 266, § 266.009

Texas Government Code

Veterans County Service Offices

Chapter 434, § 434.038

Mental Health Program for Veterans

Chapter 434, § 434.243

Program for Veterans

Chapter 434, §434.401

Inmate Welfare

Chapter 501, § 501.068

Fire Sprinkler Head Inspection

Chapter 511, § 511.0097

Grants for Veterans' Programs

Chapter 531, § 531.0992

Veteran Suicide Prevention Action Plan

Chapter 531, § 531.0925

Texas Health & Safety Code

Texas Department of State Health Services

Chapter 62, § 62.052

Public Health, Early Mental Health Intervention and Prevention of Youth Suicide

Chapter 161, § 161.325

Honoring Advance Directive or Do Not Resuscitate Order Not Aiding Suicide

Chapter 166, § 166.047, § 166.096

Personal Information

Chapter 193, § 193.005

Memorandum of Understanding on Suicide Data

Chapter 193; § 193.011

Convictions Barring Employment

Chapter 250, § 250.006

Services for Children and Youth

Chapter 533, § 533.040

Annual Status Report

Chapter 555, § 555.103

Search Warrants

Chapter 573, §573.001

Court Ordered Mental Health Services

Chapter 574, § 574.034, § 574.011

Administration of Medication to Patient under Court-Ordered Mental Health Services

Chapter 574, § 574.103

Medication Emergency Defined

Chapter 574, § 574.101, § 592.141

Administration of Medication to Client Receiving Voluntary or Involuntary Residential Care Services or to a Client Committed to Certain Residential Care Facilities

Chapter 592, § 592.152 – § 592.153

Establishment of Review Team

Chapter 672, §672.001 – §672.013

Transmitting Requests for Emergency Aid

Chapter 772, § 772.112, § 772.212, § 772.312, § 772.515 and § 772.614

Mental Health First Aid Training

Chapter 1001, § 1001.201 – §1001.206, §1001.2031

Mental Health Program for Veterans

Chapter 1001, § 1001.221 – § 1001.224

Mental Health First Aid Report

Chapter 1001, § 1001.205

Texas Human Resources Code

Office of Inspector General

Chapter 61, § 61.0451

Juvenile Correctional Officers

Chapter 242, § 242.009

Texas Occupations Code

Required Suspension, Revocation, or Refusal of License for Certain Offenses

Chapter 301, § 301.4535

Disclosure of Certain Information Relating to Occupants

Chapter 1101, § 1101.556

Training and Education for School District Peace Officers and School Resource Officers

Chapter 1701, § 1701.262-§ 1701.263

Texas Penal Code

Protection of Life or Health

Chapter 9, § 9.34

Aiding Suicide

Chapter 22, § 22.08

Making a Firearm Accessible to a Child

Chapter 46, § 46.13

Texas Property Code

Reporting a Suicide on a Property

Chapter 5, § 5.008

Designations from 86th Legislative Session

Veterans Suicide and PTSD Awareness Month

Concurrent Resolution

- WHEREAS, The veterans of the armed forces of the United States experience post-traumatic stress disorder and commit suicide at rates far higher than the general population; and
- WHEREAS, The men and women who bear arms in our defense regularly face traumatic situations that are not necessarily unique to military life but are certainly more prevalent, ranging from violent and life-threatening experiences to sexual harassment and assault; and
- WHEREAS, Between 7 and 8 percent of the general population experience PTSD at some point in their lives, but veterans are afflicted at rates that range from 12 percent for those who took part in the Gulf War to between 11 and 20 percent for veterans of Operations Iraqi Freedom and Enduring Freedom; approximately 15 percent of Vietnam veterans are currently diagnosed with PTSD, and nearly a third of them have experienced the condition over the course of their lifetimes; and
- WHEREAS, The aftermath of trauma can manifest itself as depression, outbursts of anger, and substance abuse, but the most tragic consequence is suicide; from 2008 to 2016, more than 6,000 veterans each year took their own lives; moreover, in 2016, the suicide rate for veterans was 26.1 per 100,000 as opposed to 17.4 for non-veteran adults, when adjusted for age and gender; and
- WHEREAS, Suicide and other consequences of PTSD affect not only the veterans themselves, but also their families, friends, and communities; in an effort to address this urgent problem, the U.S. Department of Veterans Affairs, the Department of Defense, the Department of Homeland Security,

the National Action Alliance for Suicide Prevention, and many veterans and private sector organizations are working to expand treatment and prevention services; these initiatives can be furthered by increasing public awareness of the issue and by engaging the active support of a broad spectrum of concerned citizens; and

- WHEREAS, Americans owe those men and women who sacrificed so much on our behalf an eternal debt of gratitude, and it is essential that our veterans receive the assistance they need to enhance their well-being and their ability to live long and fulfilling lives; now, therefore, be it
- RESOLVED, That the 86th Legislature of the State of Texas hereby designate June as Veteran Suicide and PTSD Awareness Month; and, be it further
- RESOLVED, That, in accordance with the provisions of Section 391.004(d), Government Code, this designation remain in effect until the 10th anniversary of the date this resolution is finally passed by the legislature.

Texas Suicide Prevention Week

Concurrent Resolution

- WHEREAS, The observance of National Suicide Prevention Month in September provides a fitting opportunity to heighten understanding of this critical public health issue; and
- WHEREAS, Each year in the United States, more than twice as many people die from suicide as from homicide, and suicide has become an issue of ever more pressing concern in recent decades; from 1999 to 2016, rates of suicide rose in nearly every state, and Texas experienced an 18.9 percent increase during that time period; and
- WHEREAS, Although suicide is difficult to predict, it is often preceded by warning signs, and sudden changes in mood and behavior can indicate that an individual may need help; the concern expressed by friends, parents, and other family members can make a tremendous difference to someone who is struggling with suicidal thoughts; and
- WHEREAS, Evidence shows that suicides can be reduced by teaching coping and problem-solving skills; many individuals can also find relief from depression and other emotional pressures through therapy, and it is vital that the public be made aware of available treatment options, including psychological counseling; and
- WHEREAS, Education initiatives can be especially helpful for young people; suicide is the second leading cause of death among primary and secondary students ages 10 and older, and a concerted outreach effort in public schools

can be an effective means of engaging students, their families, and the wider community; and

- WHEREAS, Suicide exacts a heavy toll on our state, leaving far too many people to cope with the sudden loss of someone they hold dear, and a greater awareness of suicide warning signs and intervention strategies can play an important part in reducing the number of these senseless tragedies; now, therefore, be it
- RESOLVED, That the 86th Legislature of the State of Texas hereby designate September as Suicide Prevention Month; and, be it further
- RESOLVED, That in accordance with the provisions of Section 391.004(d), Government Code, this designation remain in effect until the 10th anniversary of the date this resolution is finally passed by the legislature.

Appendix C. List of Acronyms

Acronym	Full Name
ACA	American Correctional Association
AIDS	Acquired Immune Deficiency Syndrome
AFSP	American Foundation for Suicide Prevention
ASIST	Applied Suicide Intervention Skills Training
BRFSS	Behavioral Risk Factor Surveillance System
CAMS	Collaborative Assessment and Management System
CDC	Centers for Disease Control and Prevention
CMC	Correctional Managed Care
CMI	Chronically Mentally Ill
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
EAC	Emergency Action Center
FSS	Family Support Services
HIV	Human Immunodeficiency Virus
HHSC	Health and Human Services Commission
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
MCOT	Mobile Crisis Outreach Team
MHFA	Mental Health First Aid
MHMR	Mental Health and Mental Retardation
MHTDP	Mental Health Therapeutic Diversion Program
MRT	Master Resilience Trainer
MVPN	Military Veteran Peer Network
NSPL	National Suicide Prevention Lifeline
ORTF	Our Roadway to Freedom
OSAR	Outreach, Screening, Assessment, Referral
PADRE	Parenting Awareness Drug Risk Education
PAMIO	Program for the Aggressive Mentally Ill Offender
PESC	Psychiatric Emergency Services Centers
PHR	Public Health Region
PRC	Prevention Resource Center

Acronym	Full Name
PTSD	Post-Traumatic Stress Disorder
QMHP	Qualified Mental Health Professional
QPR	Question, Persuade, and Refer
RYSE	Resilient Youth – Safer Environments
SCI	Suicide Care Initiative
SMVF	Service members, veterans, and their families
SSIP	Suicide Early Intervention and Prevention
SVORI	Serious Violent Offender Reentry Initiative
TCJS	Texas Commission on Jail Standards
TCOLE	Texas Commission on Law Enforcement
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDCJ	Texas Department of Criminal Justice
THCIC	Texas Health Care Information Center
TJJD	Texas Juvenile Justice Department
TMD	Texas Military Department
TPCN	Texas Poison Control Network
TTOR	Texas Targeted Opioid Response
TTUHSC	Texas Tech University Health Sciences Center
TVC	Texas Veterans Commission
VMHD	Veterans Mental Health Department
YOP	Youthful Offender Program
YRBS	Youth Risk Behavior Survey
ZEST	Zero Suicide in Texas

Appendix D. Endnotes

[i] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

[ii] Centers for Disease Control and Prevention, 2019

[iii] American Foundation for Suicide Prevention, 2019

[iv] Cerel, J., Brown, M. M., Maple, M., Singleton, M., van der Venne, J., Moore, M., & Flaherty, C. (2018, March 7). How Many People Are Exposed to Suicide? Not Six. *Suicide and Life Threatening Behavior*, *49*(2), 529–534. Retrieved from https://doi.org/10.1111/sltb.12450

[v] American Foundation for Suicide Prevention, 2019

[vi] Texas State Demographer's Office and Centers for Disease Control and Prevention

[vii] Centers for Disease Control and Prevention

[viii] Crude death rate is the number of new cases (or deaths) occurring in a specified population per year, usually expressed as the number of cases per 100,000 population.

[ix] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER

[x] as defined by the U.S. Office of Management and Budget

[xi] Jobes, D. A., Berman, A. L., & Josselman, A. R. (1987). Improving the Validity and Reliability of Medical-Legal Certifications of Suicide. *Suicide and Life Threatening Behavior*, *17*(4), 310–325. Retrieved from: https://doi.org/10.1111/j.1943-278X.1987.tb00071.x

[xii] Table 83 in Appendix A

[xiii] Table 84 in Appendix A

[xiv] Table 85 in Appendix A